Prepared for Doctors of BC

February 12, 2021

Evaluation of The Facility Engagement Initiative 2.0

INTERIM EVALUATION REPORT

Ference & Company Consulting

550 - 475 West Georgia Street
Vancouver, BC V6B 4M9
www.ferenceandco.com

EXECUTIVE SUMMARY

INTRODUCTION

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 involvement in HA decisions about their work environment and the delivery of patient care. This report presents the **interim findings of the evaluation of the FEI.**

FEI activities are led and coordinated by Medical Staff Associations (MSAs) or Physician Society working groups at acute facilities throughout the province. The cost to run the FEI was just over $19M in 2019-20. The majority of program costs related to facility-level activities such as MSA governance and administrative costs; sessional costs; consultation fees; quality improvement initiatives within facilities; and cross-departmental initiatives.

Previous evaluations of the FEI demonstrated that the program was largely successful in meeting the immediate outcomes of the program, such as revitalizing MSAs, setting MSA priorities with HA consultation, and establishing good governance (among others). **The objective of the current evaluation is to assess and communicate the impacts of the FEI in relation to the expected longer-term program outcomes**:

Expected Outcomes of the FEI:
1. Improved engagement between MSAs and HAs.
2. Enhanced MSA collective voice in health system planning and decision making.
3. Improved ability of MSAs to impact quality of patient care.

A mixed-methods evaluation approach was used to examine progress toward outcomes. Data sources included: administrative and financial data; an online survey with 1,094 providers (e.g., physicians and allied health professionals) and HA representatives; and telephone interviews with 39 physicians, HA representatives, MSA project managers, and Engagement Partners (EPs). The current findings are in interim stages and as such, some limitations exist regarding the strength of the evidence.

INTERIM FINDINGS

Preliminary findings suggest that the FEI is making progress towards the expected outcomes of the program:

1. FEI structures, processes, and funded projects enabled engagement between MSAs and their local HAs.

Three key factors enabled engagement by creating **opportunities for building trust, cooperation, open communication, and collaboration** between MSA members and facility-level HA partners:

- **FEI structures**: MSA governance structures as well as project management and administrative supports enable busy medical staff to carry out engagement activities.

- **FEI processes:** 80% of MSA working groups extended 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.
- **FEI funded projects:** The majority (68%) 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.

Importantly, existing **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. Some examples included physician group consultations with facility-level HA leaders, regular meetings with facility-level HA leadership and MSAs, and collaborative departmental planning with physicians and HA partners.

> *"The level of engagement we saw from physicians with COVID-19 planning, we won't forget that. I think it has become the way of the future. The level of collaboration with administration was unprecedented. We will continue to push for that going forward."* – Physician

Note: While this was **particularly true at the facility level**, it was less so at the regional level. There was common interest among stakeholders for **greater regional engagement** to enable broader communication, collaboration, strategic planning, and implementation of FEI initiatives regionally.

2. Participation in MSA activities helped members develop a shared vision and address issues of importance to them.

Early survey results demonstrate that MSAs are supporting members to develop and amplify their collective voice, although **additional efforts are needed to ensure sufficient input from, and consultation with, MSAs** before HAs make decisions that have direct impact on physicians:

Facility-Level MSA Members and HA Partners

- Most (80%) indicated that MSAs **represent the priorities and collective interests** of their members
- Most (74%) agreed that participating in MSA activities has helped **address an issue of importance** to them
- Less than half (42%) said that MSAs are sufficiently consulted by facility leaders about facility initiatives and processes that directly impact their work environments and/or patient care

Regional-Level MSA Executives and HA Partners

- A majority (59%) agreed that MSA executives have **established a shared vision** of what they would like to achieve at regional levels
- Most (77%) said that working with MSA representatives has helped **address an issue of importance** to them
- Only one-third (35%) indicated that MSA executives are sufficiently consulted by regional-based HA leaders about initiatives and processes that directly impact their work environments and/or patient care

Interestingly, MSA involvement in HA decisions about their work environment and the delivery of patient care increased during the pandemic.

- With FEI support, **physicians participated alongside HA partners in more leadership roles** that had some influence over health system planning and decision making.
- Key Examples included: **COVID-19 working groups** and **Emergency Outbreak Committees**.

3. The FEI enabled MSAs to conduct activities that positively impacted the quality of patient care.

MSAs conducted activities and projects that either directly or indirectly **impacted quality and delivery of patient care:**

- **Direct Impacts:** Funded projects aimed to directly address issues and improve quality of patient care at a specific facility or regionally.
  - Example: Lions Gate Hospital Coastal Simulation Program
- **Indirect Impacts:** Funded activities that increase workplace satisfaction and relationships among providers support medical staff to be able to provide quality care.
  - Example: Informal gatherings and social activities such as outdoor activities and wellness events

Over half (59%) of a randomly selected sample of FEI activities addressed a quality dimension from the **BC Health Quality Matrix**, particularly one or more of the following dimensions:

Appropriate/ Effectiveness	• Improving care so that it is **appropriate to the patients' context** and **effective** in achieving intended outcomes • Example: Pediatric Eating Disorder Clinic Planning Project
Efficiency	• Identifying opportunities to **more efficiently use resources** • Example: Mission Hospital Emergency Room Flow Improvement
Access	• **Improving patient access** to services • Example: Physician and Allied Health Staff Recruitment and Retention Working Group
Safety	• Providing care that **supports patient safety** • Example: Safe Care of At-Risk Mental Health Patient Initiative

In addition, **the FEI enabled rapid development and implementation of projects related to COVID-19,** including measures to address patient and staff safety as well as increase access to continuous and quality care. Examples of FEI-funded activities and projects related to COVID-19 included planning and implementing assessment clinics, establishing hot and cold zones within facilities, providing PPE and PPE training, creating airway teams, and launching at-home care options (e.g., Hospital at Home).

Additional Preliminary Findings:

MSAs continue to establish **effective structures and processes** that enhance governance (e.g., MSA working groups that meet regularly, reference guides to support communications and procedures) and increase their capacity to carry out FEI activities.

MSAs are increasing their representativeness by **engaging providers** in FEI activities from across a variety of departments and provider types. There have been noticeable increases in participation for certain specialist physicians, such as emergency medicine physicians, anesthesiologists, psychiatrists, hospitalists, and general surgeons.

MSA members report **improved communication and relationships** among their MSAs that is facilitated by participation in FEI activities, including frequent formal meetings, informal gatherings and activities, and group training and education.

The next phase of the evaluation will be carried out in 2020-21 and will include additional data collection to further assess the impact of the FEI and identify opportunities for improvement moving forward.

TABLE OF CONTENTS

EXECUTIVE SUMMARY I

LIST OF TABLES AND FIGURES III

ACRONYMS AND ABBREVIATIONS V

1. INTRODUCTION 1

1.1 INTERIM EVALUATION OBJECTIVES AND SCOPE 1
1.2 PROGRAM PROFILE: FACILITY ENGAGEMENT INITIATIVE 2

2. METHODOLOGY 7

2.1 DATA COLLECTION METHODS 7
2.2 DATA ANALYSIS 9
2.3 LIMITATIONS 10

3. INTERIM FINDINGS AND EARLY LEARNINGS 11

3.1 PROGRESS TOWARDS EXPECTED OUTCOMES OF THE FEI 11
3.2 DESIGN, DELIVERY AND EFFICIENCY 41

APPENDICES 50

A.1 FEI LOGIC MODEL 51
A.2 FEI EVALUATION MATRIX 52

LIST OF TABLES AND FIGURES

Tables

Table 1: FEI Expected Outcomes 2
Table 2: Eligible FEI Activities 3
Table 3: Key FEI Stakeholders 4
Table 4: FEI Funding Tiers 6
Table 5: FEI Expenditures, 2019-20 6
Table 6: FEI Administrative and Financial Data 7
Table 7: Characteristics of the Survey Participants 8
Table 8: Key Informant Interview and Story Respondents 9
Table 9: Limitations of the Methodology and Mitigation Strategies 10
Table 10: FEI Activities Undertaken in Response to COVID-19, 2019-20 14
Table 11: Factors That Supported Improved Communication and Relationship Building Within MSAs 20
Table 12: HA Involvement in a Sample of COVID-19 Related FEI Activities 25
Table 13: Quality Dimension Identified for a Sample of FEI Activities 38
Table 14: Key Informants' Satisfaction with FEI Program Supports 42
Table 15: FEI Expenditures, 2019-20 45

Figures

Figure 1: FEI Activities by Number and Percentage of Project SEAT Tags, Jan 2018 to May 2020 12
Figure 2: Sample SEAT Activities by Types of Institutional Work by HA, Jan 2018 to May 2020 13
Figure 3: Number and Percentage of High Scores on Self-Assessment Forms for Statements Regarding MSA Effectiveness, 2019-20 15
Figure 4: Providers Participating in the FEI by HA, 2019-20 16
Figure 5: Providers Participating in the FEI by Practitioner Type, 2019-20 17
Figure 6: New Providers Participating in FEI by Fiscal Year, 2016-17 to 2019-20 19
Figure 8: Survey Participants Who Strongly Agreed or Agreed with Statements Regarding Engagement Within MSAs by Familiarity with the FEI, 2020 21
Figure 9: MSA Engagement of HA in a Sample of FEI Activities, Jan 2018 to May 2020 23
Figure 10: FEI Adapted IAP2 Framework 24
Figure 11: Survey Participants who Strongly Agreed or Agreed with Statements Regarding Engagement Between MSA Members and Facility-Level Leaders by Familiarity with the FEI, 2020 26
Figure 12: Percentage of High Scores on Self-Assessment Forms for Statements Regarding Facility-Level Engagement between MSAs and HAs, 2019-20 27
Figure 13: Survey Participants who Strongly Agreed or Agreed with Statements Regarding Their Influence Over Facility-Level Decision Making by Familiarity with the FEI, 2020 29
Figure 14: Survey Participants who Strongly Agreed or Agreed with Statements Regarding MSA and HA Regional Engagement, 2020 30
Figure 15: Survey Participants who Strongly Agreed or Agreed with Statements Regarding MSA and HA Engagement Related to COVID-19 Response Planning and Implementation, 2020 31
Figure 16: Program Expenditures, 2014-15 to 2019-20 46
Figure 17: Top Five Facility Expenditures, 2019-20 47
Figure 18: Program Take-Up by Entitlement Amount and Transfer Amount, 2019-20 48
Figure 19: Operating Expenditures, 2019-20 49

ACRONYMS AND ABBREVIATIONS

DoBC	Doctors of BC
EAC	Evaluation Advisory Committee
EHR	Electronic Health Record
EPs	Engagement Partners (formerly Facility Engagement Liaisons)
ER	Emergency Room
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
FNHA	First Nations Health Authority
HA	Health Authority
IAP2	Adapted International Association for Public Participation
ICU	Intensive Care Unit
IHA	Interior Health Authority
IOE	Internal Operating Expenses
MAiD	Medical Assistance in Dying
MoH	Ministry of Health
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MSA	Medical Staff Association
NHA	Northern Health Authority
OR	Operating Room
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. INTRODUCTION

This report presents the findings of the interim 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 following sections provide an overview of the objectives and scope of the interim evaluation, the FEI program, and the methodology used to conduct the evaluation.

1.1 INTERIM EVALUATION OBJECTIVES AND SCOPE

There are two main objectives of the overall evaluation: accountability and learning. Specifically, the evaluation will communicate the impacts of the FEI to stakeholders in relation to the expected outcomes of the program and identify learnings and potential opportunities for improvement.

To achieve this, an interim evaluation, guided by both outcome and process related questions, was conducted to identify preliminary findings and baseline information regarding the activities of the FEI as well as to communicate early learnings. The interim evaluation focused on the fiscal year 2019-20 and explored outcome related questions to assess the progress of the FEI towards the expected outcomes of the program, including:

- To what extent has the FEI contributed to increased Medical Staff Association (MSA) capacity and capabilities as effective, representative structures?
- To what extent has the FEI contributed to improved engagement within and amongst MSAs?
- To what extent has the FEI contributed to improved MSA and Health Authority (HA) engagement (local and regional)?
- To what extent has the FEI contributed to enhancing MSA collective voice in health system planning and decision-making?
- To what extent has the FEI enabled MSAs to impact on quality of patient care?

The process evaluation questions assessed the design, delivery, and efficiency of the program through an assessment of key program components and costs to implement the program, including:

- How satisfied are stakeholders with the investments made into key program elements?
- What was the cost to operate the program?

The interim evaluation also considered FEI outcomes and processes impacted by COVID-19 and explored specific indicators relating to the pandemic. Similar questions will be studied during the next phase of the evaluation in 2020-21 which will provide important comparative data. However, certain questions will be explored more fully, and additional areas will be investigated based on the preliminary findings from the interim evaluation.

The scope of the evaluation was determined through consultations with the Specialist Services Committee Facility Engagement Working Group (SSC FEWG) and review of the previous evaluation of the FEI.[1] It was identified that the immediate and more foundational outcomes of the program have been largely successful

[1] University of British Columbia. 2019. Facility Engagement Initiative: Final Evaluation Report, 2015-2019. http://www.facilityengagement.ca/sites/default/files/FEI%20UBC%202019%20Evaluation_Report__FINAL_0.pdf

such as revitalizing MSAs, creating capacity and competencies, setting MSA priorities with HA consultation, and establishing good governance and communications. With the immediate outcomes showing some success, the SSC FEWG agreed there was a need to assess longer-term intended outcomes of the FEI to better understand if the initiative is resulting in a sustainable foundation and relationships that lead to more meaningful engagement in HA decisions that directly impact MSAs' work environment and patient care.

1.2 PROGRAM PROFILE: FACILITY ENGAGEMENT INITIATIVE

1.2.1 Program 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.[2] The FEI was established through the 2014 Physician Master Agreement and officially launched on January 1, 2015 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 involvement in HA decisions 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 1 below.

Table 1: 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 or inter-regional level, 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.

1.2.2 Program Activities

FEI activities are led and coordinated by 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

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

midwives) who engage with HAs to collaboratively address health care system challenges and support quality patient care.[3,4] An MSA consists of an executive team (i.e., President, Vice President, and Secretary treasurer) that represents the medical staff at the Medical Staff Advisory and Executive Committee 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.

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 expertise to support them (e.g., a coordinator for administrative support, a 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 2 below.

Table 2: 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
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.
Other	• Other costs contributing to the objectives of the MoU, including for activities related to electronic health record (EHR) training.

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

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.[5]

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 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.

Staff resources are also made available for MSAs, including Engagement Partners – EPs (formally known as Facility Engagement Liaisons - FELs) who support the establishment of MSA working groups according to FEI guidelines and liaise with key HA stakeholders. 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).

1.2.3 Program Stakeholders

Participation in the FEI is open to all HAs and their facilities with acute care beds, and physicians with privileges inside BC facilities who are members of the medical staff. Medical staff membership includes specialists, general practitioners, and alternatively paid physicians. Non-physicians such as dentists, nurse practitioners, and midwives may also be invited to participate by MSAs as non-voting members or guests. As of February 2020, across BC's acute care facilities and programs, 72 MSAs in six HAs and more than 5,200 physicians and other providers have participated in 2600+ Facility Engagement activities. Table 3 below describes the full scope of internal and external program stakeholders.

Table 3: Key FEI Stakeholders

Stakeholder	Description
Internal Stakeholders	
FEI-Involved Health Care Providers	BC health care providers that engage with the FEI are directly involved in FEI activities and are therefore 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 has overall responsibility for the implementation and monitoring of the FEI. 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.

[5] Facility Engagement. 2020. Funding Guidelines. https://live-facility-engagement.pantheonsite.io/sites/default/files/SSC%20Facility%20Engagement%20Funding%20Guidelines__CO_CHAIR%20LETTER%20ONLY%20Nov%202020%20%28ID%20383177%29.pdf

HAs	As part of their leadership and management function, the HAs are interested in the overall effectiveness and identified impacts of the FEI.
External Stakeholders	
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 and is therefore interested in the accountability of SSC for its stewardship of funding, as well as any impacts identified related to the per capita cost of health care.

1.2.4 Program Governance

Regional 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).[6] 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 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

The MSA working group advises MSA executives on matters of importance to medical staff, their patients, and the HA. 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 and HA. 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.

[6] Ministry of Health, Health Authorities, and Doctors of BC. 2019. Memorandum of Understanding. https://facilityengagement.ca/sites/default/files/PMA%202019_Memorandum%20of%20Understanding%20Regional%20and%20Local%20Engagement.pdf

1.2.5 Program 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). Table 4 below outlines the funding tiers for the FEI. 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 4: FEI Funding Tiers

Funding Tier	# of Acute Care Beds	# of Facilities	Available Full Funding Per Year
Tier 6	301+	9	$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	13	$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 2019-20. The majority of program costs related to facility-level expenditures on engagement activities, including sessional costs, internal operating expenses, and office and communication expenses to support MSA operations. A smaller proportion of expenses supported the provincial office to operate the FEI, such as staff salaries and benefits, overtime expenses, outside help, and training and development. Table 5 below outlines program resources for 2019-20.

Table 5: FEI Expenditures, 2019-20

Expenditures	2019-20
Facility Expenditures	$16,838,145
Operating Expenditures	$2,532,188
Total	**$19,370,333**

2. METHODOLOGY

An evaluation matrix was developed to guide the evaluation, which included relevant indicators and data collection methods for each of the outcome and process evaluation questions. The evaluation matrix 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.

2.1 DATA COLLECTION METHODS

A combination of methods was used to collect data in support of the interim evaluation. The following provides an overview of the methodologies.

2.1.1 Administrative and Financial Data

A systematic analysis of the financial and administrative data related to the FEI was conducted to gain a detailed understanding of the nature of FEI activities to answer questions pertaining to both the expected outcomes of the program as well as program costs. The specific data sources utilized for the evaluation are outlined in the table below.

Table 6: FEI Administrative and Financial Data

Type of Data	Description
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
COVID-19 Activity Tracker	• A temporary database used to track FEI activities undertaken by MSAs in response to COVID-19
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)
EP Data	• Data collected by EPs on specific data points of interest for the evaluation (e.g., standing invitations or meetings between MSAs and HAs)

2.1.2 Online Survey

A 10-minute province-wide survey was conducted online with providers and HA representatives to collect quantitative and some qualitative data to answer questions pertaining to the expected outcomes of the FEI. The survey was launched on July 22, 2020 and closed on September 1, 2020. In total, 1,094 medical and HA staff participated in the survey. The survey achieved an estimated 20 per cent response rate when compared to the original contact list. However, due to the open link provided to participants to share, the true

denominator for the response rate is unknown. The following table provides an overview of the participants by role, leadership status, years of clinical experience, HA, and familiarity with FEI.

Table 7: Characteristics of the Survey Participants

Participant Characteristics		Number of Responses (n)	Proportion of Total (%)
Role			
MSA Member	Physician	931	85.1%
	Nurse Practitioner	12	1.1%
	Midwife	12	1.1%
	Dentist	2	0.2%
Non-MSA Member (e.g., HA leadership and staff)		137	12.5%
Total		**1,094**	**100.0%**
Leadership Status			
None (i.e., no formal leadership role)		808	73.9%
Facility-level leader		160	14.6%
Regional or sub-regional leader		160	8.9%
Other leader (e.g., provincial level leader)		6	0.6%
Leader at multiple levels		23	2.1%
Total		**1,094**	**100.0%**
Years of Clinical Experience			
0 or n/a		22	2.0%
>0 and <2		19	1.7%
2-5		152	13.9%
6-10		192	17.6%
11-15		138	12.6%
16-20		139	12.7%
21-25		127	11.6%
26+		305	27.9%
Total		**1,094**	**100.0%**
Health Authority			
First Nations Health Authority (FNHA)		2	0.2%
Fraser Health (FHA)		224	20.5%
Interior Health (IHA)		263	24.0%
Island Health (VIHA)		203	18.6%
Northern Health (NHA)		95	8.7%
Providence Health Care		45	4.1%
Provincial Health Services Authority (PHSA)		80	7.3%
Vancouver Coastal Health (VCH)		182	16.6%
Total		**1,094**	**100.0%**
Familiarity with FEI			
1 – Not at all familiar		66	1.6%
2		71	3.4%
3 – Somewhat familiar		276	20.1%
4		315	30.5%
5 – Very familiar		366	44.4%
Total		**1,094**	**100.0%**

2.1.3 Telephone Interviews

Thirty- to sixty-minute telephone interviews were conducted with a sample of physicians, HA representatives, MSA project managers, and EPs to collect qualitative data on questions related to the expected outcomes of the FEI and satisfaction with key program supports as well as rich data to create stories that highlight the impact of FEI activities and processes. Interviews took place between July 2020 and November 2020. In total, 22 key informants participated in the interviews related to program satisfaction and supports, and 17 key informants participated in the development of stories. The following table provides an overview of the key informants.

Table 8: Key Informant Interview and Story Respondents

Type of Respondent	Number of Key Informants (n)	Proportion of Sub-Total (%)
Interviews		
Physicians	10	45%
EPs	5	23%
HA Representatives	4	18%
MSA Project Managers	3	14%
Sub-Total	**22**	**100%**
Stories		
Physicians	7	41%
HA Representatives	5	29%
MSA Project Managers	3	18%
EPs	1	6%
External Stakeholders	1	6%
Sub-Total	**17**	**100%**

2.2 DATA ANALYSIS

Data from each of the lines of evidence were synthesized and analyzed in a results matrix. Specifically, the data from each line of evidence (i.e., administrative and financial data, survey, and interviews) were compiled and summarized by evaluation question and indicator in a results matrix. The data for each indicator were reviewed to develop a summary response or preliminary conclusion for each evaluation question. The relative strengths and limitations associated with line of inquiry were considered during this process. Greater priority was placed on data and themes considered to be more reliable or more relevant to the respective indicator and study question. The results matrix was then used to inform creation of the interim evaluation report.

In addition, data from the lines of evidence, particularly SEAT data, were analysed and categorized according to relevant frameworks including:

- **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).[7]

[7] 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

- **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.[8]
- **BC Health Quality Matrix:** A matrix used to assess FEI activities by dimensions of quality of patient care.[9]

2.3 LIMITATIONS

There were some methodological limitations and challenges encountered during the interim evaluation. Table 9 outlines the key limitations and the strategies employed to mitigate them.

Table 9: Limitations of the Methodology and Mitigation Strategies

Limitations	Mitigation
SRRP Data: Information collected as part of the SRRP was subject to positive response bias due to the vested interests of the stakeholders providing data for the review	SRRP data was triangulated with other types of data (e.g., survey and interview data) to reduce the impacts of positive response bias
SEAT Data: There were some inconsistencies with the quality of the SEAT entries (e.g., some descriptions of activities were more complete than others)	A random sample of representative SEAT activities was utilized to minimize selection bias of the entries (e.g., to avoid selecting and analyzing only complete entries)
FEMS Data: Expenditures and take-up of the FEI were challenging to assess due to inconsistent financial data provided as well as carry-over funds from previous fiscal years	Limitations of this analysis are noted in the report and will be further assessed during the next phase of the evaluation when comparative data is available
Survey Analysis: Exploratory sub-group analyses were conducted during the interim phase of the evaluation (i.e., statistical significance of sub-group differences was not tested)	Tests of statistical significance will be conducted in the next phase of the evaluation when additional survey data is collected so some caution should be exercised when reviewing sub-group survey results
Interview Analysis: There were a low number of key informants interviewed for the interim phase of the evaluation which may impact the reliability of the data, particularly for sub-group findings	Interview data was triangulated with other types of data (e.g., SRRP and survey data) to reduce the impacts of low representation but some caution should be exercised when reviewing sub-group interview results

[8] Doctors of BC. 2019. Facility Engagement Initiative (FEI) – Planning and Evaluation Toolkit 2019. https://facilityengagement.ca/sites/default/files/FE_Evaluation%20Toolkit%20FINAL%20FILLABLE%20%28ID%20224779%29.pdf
[9] BC Patient Safety and Quality Council. 2020. Dimensions of Quality. https://bcpsqc.ca/what-is-quality/

3. INTERIM FINDINGS AND EARLY LEARNINGS

3.1 PROGRESS TOWARDS EXPECTED OUTCOMES OF THE FEI

The following sections outline the preliminary findings and early learnings from the interim evaluation of the FEI. Key findings are presented for each of the expected outcomes of the program, including:

- Increased MSA capacity and capabilities as effective, representative structures
- Improved engagement within and amongst MSAs
- Improved engagement between MSAs and HAs
- Enhanced MSA collective voice in health system planning and decision-making
- Improved ability of MSAs to impact quality of patient care

At the end of each section, a summary of early learnings is provided which identifies opportunities for the program, MSAs, HAs, and the evaluation to consider. It is important to note that these early learnings and opportunities are not conclusive recommendations, as the findings are still in interim/preliminary stages.

Expected Outcome 1: To what extent has the FEI helped to increase the capacity and capabilities of MSAs as effective and representative structures?

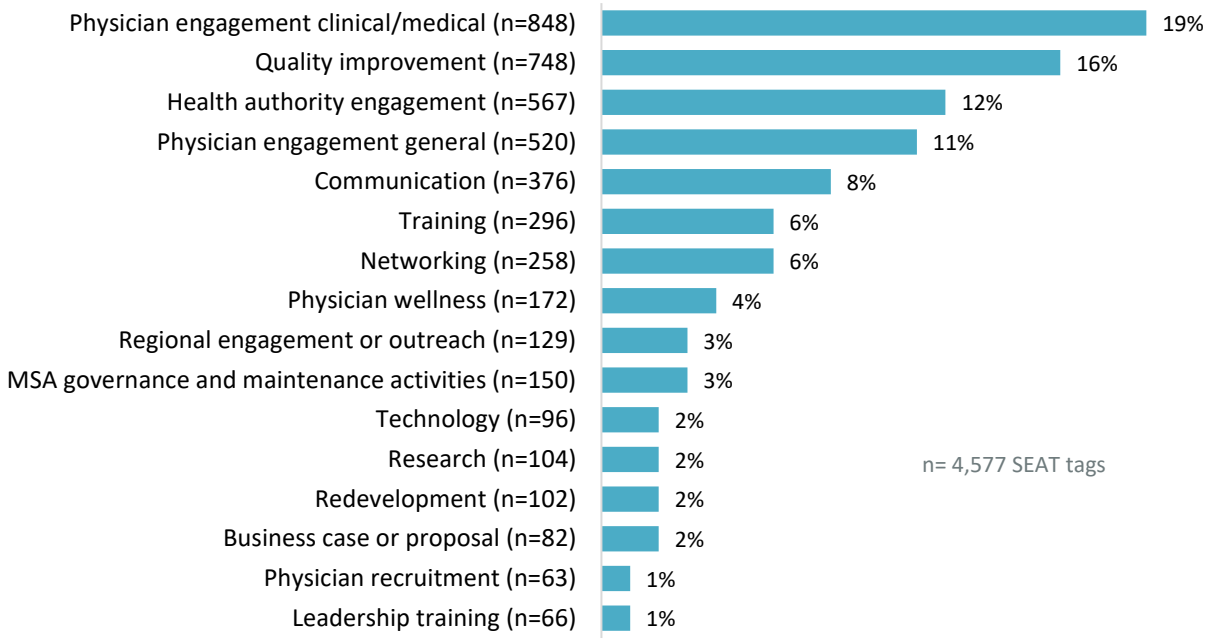
One of the shorter-term outcomes of the FEI is to contribute to increased capacity and capabilities of MSAs as effective, representative structures. This outcome was assessed by examining FEI contributions to the number and type of MSA engagement activities undertaken, the effectiveness of MSAs, and the representativeness of MSA members.

Preliminary Finding 1: Through FEI support, MSAs were enabled to undertake over 2,000 engagement activities (e.g., strategic meetings, training and educational events, quality improvement discussions, etc.), including activities in response to COVID-19 such as meetings, communications, and training.

From approximately January 2018 to May 2020, 2,141 engagement activities had been undertaken by MSAs through the FEI.[10] Each activity was assigned up to three activity tags (i.e., activity categories), for a total of 4,577 tags. As illustrated in Figure 1 below, the largest number and proportion of project SEAT tags pertained to clinical/medical physician engagement (n=848; 19%), quality improvement (n=748; 16%), HA engagement (n=567; 12%), and general physician engagement (n=520; 11%). A few key informants noted that many of these activities would not have taken place without the FEI, as the compensation for physician time and administrative support provided through the FEI is integral to the capacity and capabilities of MSAs to carry out the activities.

[10] Number of FEI activities were determined through an analysis of the SEAT database. It was not possible to determine only the activities that fell within the evaluation period as the SEAT database does not capture information on activity dates and many activities spanned multiple fiscal years. As such, the 2,141 activities represent a snapshot of activities that existed in the database as of the date of extraction (May 2020). The earliest data entry date was in January 2018.

Figure 1: FEI Activities by Number and Percentage of Project SEAT Tags, Jan 2018 to May 2020



To better understand the type of activities undertaken through the FEI, a representative sample of 5% (n=107) of activities were selected from the SEAT database and analyzed in relation to the institutional work framework.[11] [12] Across HAs, the activities included:

- **Conceptual activities** accounted for the majority (n=82; 77%) of the sample activities (Figure 2), where MSA members worked to establish and communicate ideas and beliefs consistent with intended changes. Some examples of these activities included physician focus groups held to gain a deeper understanding of how cancer care services can be improved from the medical/physician perspective, training ER and other critical care physicians to better manage critical care events or procedures in a rural, remote hospital, and a quality improvement initiative underway to improve organization of supplies in an emergency department to enhance efficiency.

- **Relational activities** accounted for 15% (n=16) of sample activities, where efforts were made to build connections, trust, and collaboration within the medical profession and with health system managers (e.g., a department-specific meet and greet session for sharing experiences, collaborative activities for supporting opportunities that fostered collegiality between hospital and local community physicians, and a facility-specific annual event that provided engagement opportunities for team building).

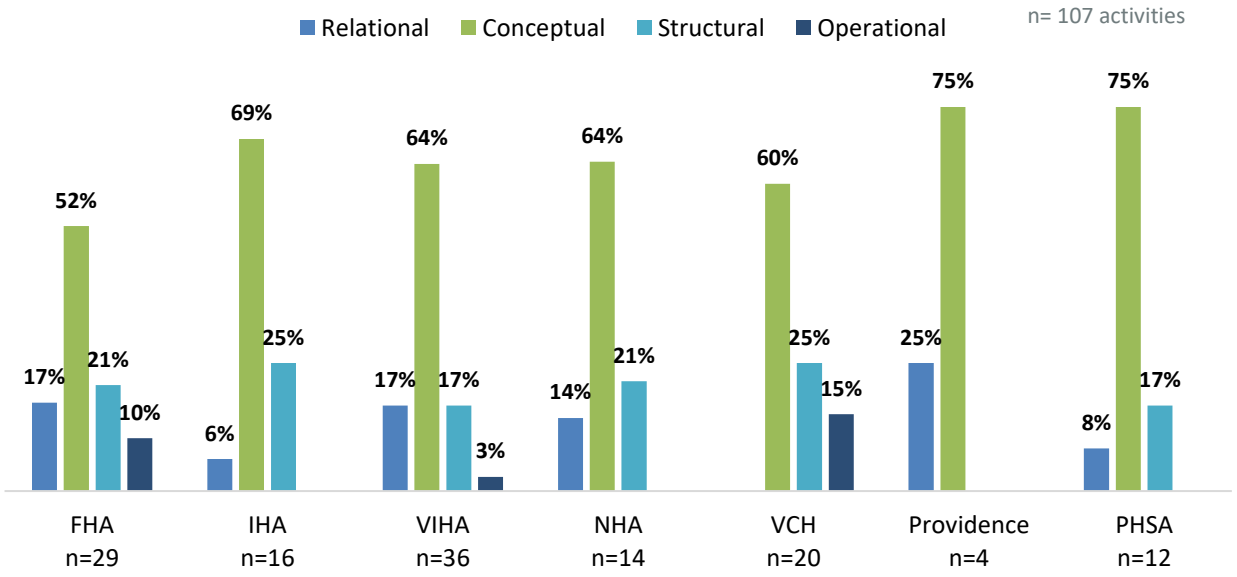
[11] To support representativeness, activities were first categorized by HA, funding tier, medical area (e.g., emergency medicine, radiology, neurology, etc.), and status (i.e., on hold, in progress, complete, no status assigned) and then a random sample was selected across these categories.

[12] Activities were analyzed and classified using Types of Institutional Work (i.e., relational, conceptual, structural, and operational). Some activities aligned with multiple stages, so some duplicates existed. Further, some caution should be used while interpreting these results, as activities were not classified by those directly involved in the activities and therefore, misclassification could have occurred for activities with a short or incomplete description.

- **Structural activities** accounted for 24% (n=26) of sample activities, where efforts were made to establish formalized roles, rules, and policies that support intended changes (e.g., review and implementation of a new procedure to decrease caesarean section rates and better use limited nursing resources and implementation of policies and procedures to address gaps in access to local midwifery care in a rural community).

- **Operational activities** accounted for a small portion of conducted activities (n=7; 7%) where efforts were made to implement concrete initiatives and actions that advance or cement in place desired changes (e.g., an ambulatory care centre improvement project that was completed in partnership with the HA and has resulted in new efficiencies and reallocation of resources to enhance the quality and quantity of health services delivered).

Figure 2: Sample SEAT Activities by Types of Institutional Work by HA, Jan 2018 to May 2020



Interestingly, a few EAC stakeholders noted that these findings are consistent with their expectations for the FEI, where FEI funding and support is most appropriate for conceptual activities (e.g., training and educational events, quality improvement discussions, etc.). It was noted that if activities evolve into more structural or operational endeavours, a greater number of stakeholders typically become involved and additional external funding is accessed (e.g., funding from the HAs). Ultimately, the theory of change for the FEI would suggest activities conducted at the conceptual level are an important foundation for more structural and operational activities, regardless of whether these activities are funded under the FEI. This will be explored further in later phases of the evaluation, including the theory that those successful conceptual activities may result in structural and operational changes overtime.

FEI Activities Undertaken by MSAs in Response to COVID-19

Given the serious and widespread impacts of the COVID-19 pandemic on health care systems as well as the FEI, a separate analysis was conducted of FEI activities undertaken in response to COVID-19. During the latter part of 2019-20, EPs reported 128 COVID-19 related activities and 2,386 FEMS claims were submitted for

activities undertaken in response to the pandemic.[13] To better understand the type of COVID-19 activities undertaken through the FEI, a representative sample of 33% (n=42) of activities were selected from the COVID-19 Activity Tracker. The activities were related to meetings (52%; n=22), communications (19%; n=8), meals for physicians (14%; n=6), training (12%; n=5), and physician wellness initiatives (2%; n=1). The following table provides an overview of these activities including key objectives, stakeholders, and outcomes.

Table 10: FEI Activities Undertaken in Response to COVID-19, 2019-20

Activity Type	Description	Objective	Stakeholders	Outcomes
Meetings	Compensation for physicians to take part in meetings to plan their response to COVID-19. Meeting topics included, but were not limited to, strategy planning on airway management plans, strategic planning for perinatal services, patient workflow management meetings, and participation in Emergency Outbreak Committees	Formal acknowledgement of physicians' time spent on COVID-19 pandemic and ensure plans and protocols implemented are effective to navigate through the pandemic.	MSA executives, staff and working group members, physicians working in conjunction with MSA/HA for COVID-19 response	Strong physician engagement and involvement in COVID-19 response planning, development of standardized procedures and protocol, enhanced awareness among MSA members, connection of non-frontline physicians to the COVID-19 response, improved access to care for COVID-19 and non-COVID-19 patients
Communication	Included support for frequent phone calls and email exchanges among MSA staff, virtual town hall meetings, virtual meetings among physicians to support ongoing pandemic communications, use of Slack and WhatsApp as secure communications tools among medical staff. Also included physician providing a localized version of Dr. Bonnie Henry's daily updates via social media.	Streamlining and supporting enhanced communications among medical staff	MSA staff, facility physicians, member of local tribal council, members of the general public in local communities	High levels of medical staff satisfaction, improved workflow at hospital facilities, sustained connection to local communities regarding evolution of COVID-19
Training	Included intubation training simulation for patients suffering severe symptoms of COVID-19 and tutorials on safe techniques for donning/doffing enhanced Personal Protective Equipment (PPE).	Improve competence and confidence of medical staff in ER during the COVID-19 pandemic	Physicians (e.g., Intensive Care Unit (ICU) intensivists, anesthesiologists, etc.), nursing staff, paramedics	Increased confidence of medical staff in carrying out procedures, identification of deficiencies and ways to improve safety and reduce risk of exposure in the management of COVID-19 patients, improved medical staff satisfaction levels
Meals	Included MSA providing healthy snacks for physicians in the lounge to support physician wellness through the pandemic, MSA purchase of espresso machines for doctors' lounge, MSA	Support medical staff working long hours in the hospitals and limit their contacts outside of hospital facilities (i.e., in	Physicians working at the hospital facilities	Improved staff satisfaction levels

[13] Due to variability in how SEAT data is entered, it was not possible to determine the exact number of COVID-19 related FEI activities. Instead, EPs were asked to report on COVID-19 related activities occurring at their site using the COVID-19 Activity Tracker. However, EPs are not involved in all activities of the MSAs and therefore, the list may be an underrepresentation of the amount of activities undertaken in response to COVID-19.

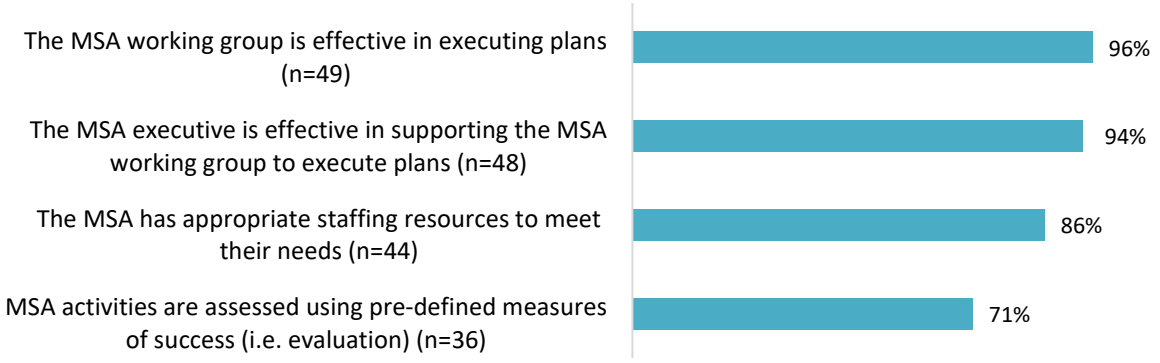
	supporting physicians by ordering groceries.	restaurants and grocery stores) to minimize the spread of COVID-19		
Physician wellness	MSA provided tokens of appreciation for medical staff such as the Chief of Staff, Deputy Chief of Staff as well as other staff	Boost morale of medical staff working through the pandemic	ER staff	Improved morale, empowerment, and facility cohesion as well as possible job satisfaction

Consistent with previous findings, most COVID-19 related FEI activities (93%; n=42) were conceptual in nature, as they frequently pertained to education and communications activities to support medical staff involvement in the health care response to the pandemic. A few activities (7%; n=3) were structural, as they entailed identification of policy or process needs and implementation of concrete actions to address needs identified (e.g., development and implementation of an anesthesia airway response team and protocol for managing COVID-19 suspected and positive patients).

Preliminary Finding 2: Through administrative and financial support, the FEI has supported MSAs to establish effective structures and processes that enhanced governance (e.g., MSA working groups that meet regularly, reference guides to support communications and procedures) and increased capacity to carry out FEI activities.

Findings from the SRRP self-assessment forms completed by 51 (77%) participating facilities, indicated that the majority of MSAs rated themselves as either always or frequently effective in executing plans through the support of the MSA executive and appropriate staffing resources.[14] Slightly fewer reported that MSA activities were always or frequently assessed using pre-defined measures of success, suggesting some room for improvement regarding the ongoing evaluation of FEI activities. Figure 3 below illustrates the specific number and percentage of MSAs who provided high scores on these items.

Figure 3: Number and Percentage of High Scores on Self-Assessment Forms for Statements Regarding MSA Effectiveness, 2019-20



[14] As of May 27, 2020, 51/66 (77%) of MSAs had submitted self-assessment forms for 2019-20. One site was required to participate in the 2019-20 SRRP process before they were live in FEMS, which explains the 66 MSAs reported in the SRRP data as compared to the 65 MSAs reported in FEMS for 2019-20.

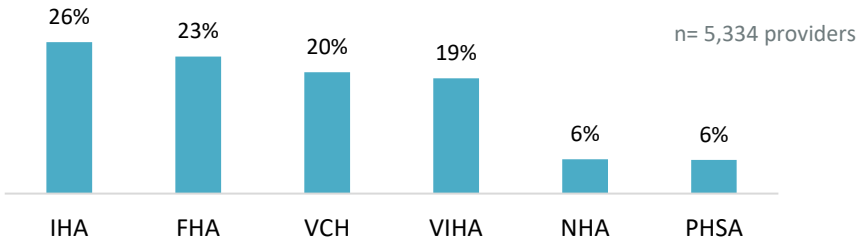
Several key informants across all groups (i.e., physicians, HA representatives, MSA project managers, and EPs) indicated that the FEI supported MSAs with effective structures and processes (e.g., administrative and financial support) that enhanced governance processes and increased the effectiveness of MSAs as a cohesive group. Some examples provided by physicians of how MSAs' effectiveness has increased as a result of the FEI include the development of an MSA reference guide to identify and communicate roles, procedures, and a calendar of events, producing meeting minutes in a format that is appropriate for review by the medical advisory committee, and the creation of a working group that meets on a monthly basis to discuss key issues and concerns.

"Prior to the FEI, every MSA was different and historically our MSA had some structure and membership. But the formation of the FEI gave it further structure and gave us a route to effective communications with local leadership. It gave meaning and purpose to our MSA." – Physician

Preliminary Finding 3: The FEI supported enhanced representativeness of the MSAs by engaging providers from across a diversity of departments and provider types. For example, over the past few years, there were noticeable increases in participation for certain specialist physicians including emergency medicine physicians, anesthesiologists, psychiatrists, hospitalists, and general surgeons as well as dentists, registered nurses, and allied health professionals.

Administrative data demonstrates that in 2019-20, there were 65 active MSAs involved in FEI with a total of 5,334 participating providers (i.e., MSA Members and other providers such as allied health staff).[15] As illustrated in Figure 4 below, there was participation across all regional HAs including: IHA (26%; n= 1,386), FHA (23%; n=1,227), VCH (20%; n=1,066), VIHA (19%; n=1,013), NHA (6%; n=320), and PHSA (6%; n=320).

Figure 4: Providers Participating in the FEI by HA, 2019-20



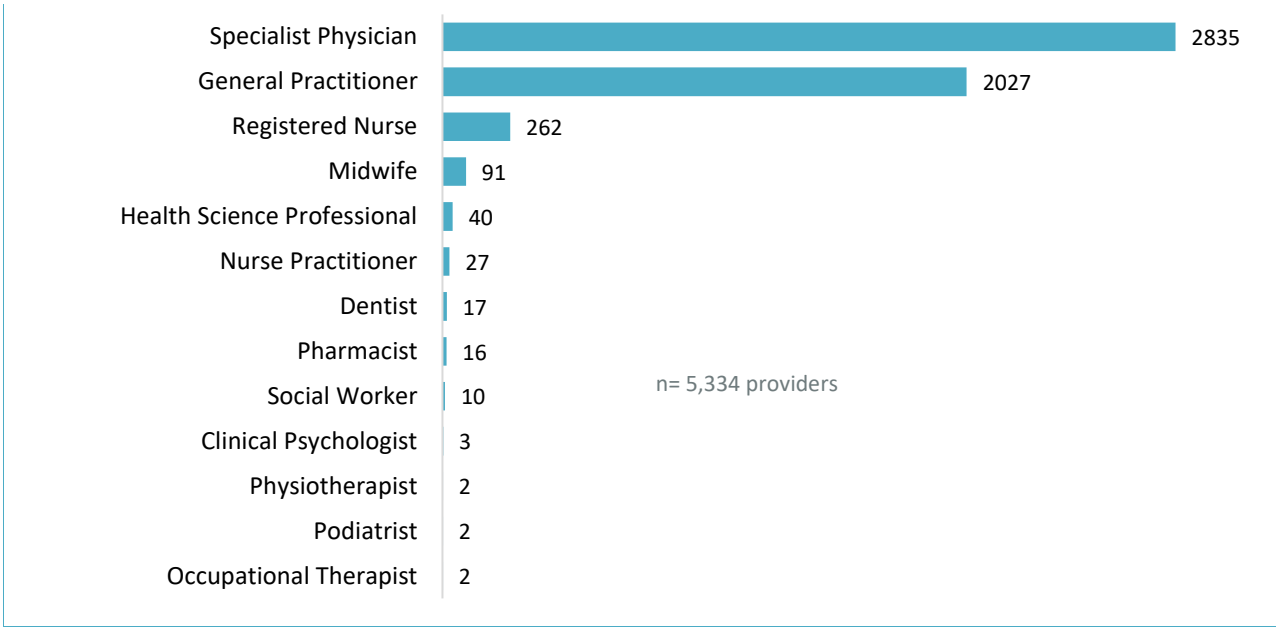
Most of the providers were either specialist physicians (53%; n=2835) or general practitioners (38%; n=2027), with some representation from other providers such as registered nurses, midwifes, and health science professionals (Figure 5).[16] Interestingly, an examination of new providers accessing the FEI demonstrated noticeable increases in participation for certain specialist physicians including emergency medicine physicians, anesthesiologists, psychiatrists, hospitalists, and general surgeons. For example, 118 (48%) of the 247 hospitalists joined in 2018. There was also some increase in representation among certain practitioners such

[15] Although 71 sites have been involved in FEI since its inception, in 2019-20, 65 MSAs were active in FEMS. The others (e.g., sites in start-up mode) are either still with Doctors of BC for claims processing and will be in FEMS soon or have not applied for full funding this year yet.

[16] Participation in the FEI was measured by examining MSA members' activity in FEMS (e.g., date joined, account activity)

as dentists, registered nurses, and allied health professionals increased in recent years. For example, 156 (60%) of the 262 registered nurses recently accessed the FEI in 2019.

Figure 5: Providers Participating in the FEI by Practitioner Type, 2019-20



Several key informants (particularly physicians and MSA project managers) noted that, as result of the FEI, there was increased interest and involvement in the MSAs which helped to increase the representativeness of the MSAs by incenting new participation across a diversity of departments and provider types (e.g., non-physicians such as allied health professionals). In particular, some key informants noted that the level of participation in projects increased significantly as a result of interest in FEI activities and in turn, helped to improve representativeness of participating MSAs. Finally, data from the EPs identified that most (91%; n=64) of MSA working groups engaging in the FEI were considered to be representative based on the facility's terms of reference.[17] The remaining facilities were either uncertain that the working groups were representative or indicated they were not.

Preliminary Finding 4: The existing MSA structures and processes supported by the FEI helped MSAs to mobilize quickly to respond to the COVID-19 pandemic, as the necessary human and financial resources were already in place when the pandemic response was initiated (e.g., governance structure, funds, administrative support).

Key informants and survey participants identified that the existing MSA structures and processes, along with the nimble nature of the program (i.e., non-prescriptive, physician-led), helped MSAs to mobilize quickly to respond to COVID-19, as the necessary human and financial resources were already in place when the pandemic response was initiated. For example, survey participants (n=40) identified through their qualitative responses that the FEI structures and processes enabled access to quick distribution of funds and information and provided leadership and administrative resources and support necessary to carry out activities in response

[17] Information regarding each MSAs' specific terms of reference were not provided and could be provided for the final evaluation.

to the pandemic.[18] Examples of COVID-19 rapid responses supported through the FEI included the development of a specialized airway access team including physicians and HA staff to mitigate risk of COVID-19 infection amongst providers and shifting clinics from in-person to virtual delivery to maintain service delivery for patients through the pandemic.

Early Learnings to Further Support MSAs to be Effective and Representative Structures:

Program Opportunity: Encourage and support MSA working groups to access governance support material, including succession planning resources, that will be released in 2021.

- One limitation identified by the evaluation was that only 15 (21%) of MSA working groups had succession plans in place. Succession plans are an important process for identifying and ensuring new leaders and staff are available and prepared to replace current resources when they become unavailable. Succession plans can support MSAs in smooth transition points between leaders and staff to support their ongoing effectiveness.

HA and MSA Opportunity: Consider whether identity factors (e.g., gender, ethnicity, age, or other factors) should be examined when reviewing MSA representativeness.

- MSA representativeness was examined by each facility primarily through review of the involvement of hospitals/departments. An assessment of representativeness was not undertaken with regards to identity factors such as gender, ethnicity, age, or other factors. However, there were some suggestions by survey participants (n=15) to improve inclusivity and address systemic barriers within MSAs to increase participation (e.g., gender bias) so MSAs may consider expanding their definition of representativeness.

Expected Outcome 2: To what extent has the FEI helped to improve engagement (e.g., increased communication and relationships) between the members of an MSA as well as amongst MSAs at different facilities?

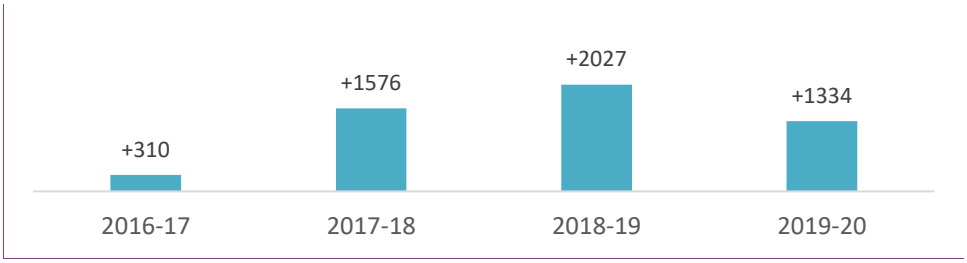
One of the key outcomes of the FEI is to contribute to improved engagement within and amongst MSAs. This outcome was assessed by examining the participation rates of MSA members and allied health staff in FEI activities and the contribution of these various activities in improving engagement (e.g., communication and relationship building) within MSAs as well as amongst MSAs.

Preliminary Finding 1: Nearly 5,000 MSA members and over 400 allied health staff have participated in FEI activities since inception. Over half of physician survey participants (57%; n=338) and to a lesser extent non-MSA members such as HA staff (38%; n=37), agreed or strongly agreed that MSA participation re-energizes their work.

[18] Only a small percentage of the survey participants provided written feedback to certain questions, so the number of respondents is lower in caparison to quantitative scale questions. Because of this, qualitative survey responses are presented without percentages.

Since inception, 5,334 providers (i.e., nearly 5000 MSA members and over 400 allied health staff) have participated in the FEI.[19] Figure 6 below illustrates the number of new providers who participated in the FEI each year since 2016-17. New providers have participated in the FEI each fiscal year from 2016-17 to 2019-20.

Figure 6: New Providers Participating in FEI by Fiscal Year, 2016-17 to 2019-20



The FEI incentivises participation by offering sessional payments for MSA members that are engaging in FEI activities (e.g., meetings), a common practice noted to improve engagement in physician engagement literature.[20] Indeed, survey participants (n=148) in their qualitative responses identified sessional funding as a key contributor to enabling and encouraging physician involvement in engagement activities and initiatives. In addition, the evaluation found there was an increase in the amount of time practitioners spent on FEI activities compared to previous years. In 2019-20, sessional expenditures accounted for nearly half (44%) of the 65 MSA facility expenses for the FEI, this represented a change from the previous year where fewer sessional claims were made (39%).

Facility-level survey participants (n=723), particularly physicians (57%; n=338) and to a lesser extent non-MSA members such as HA staff (38%; n=37), agreed or strongly agreed that MSA participation re-energizes their work, suggesting the importance of continuing to engage new and current members in the work of the MSAs, such as the FEI.

Preliminary Finding 2: Through FEI activities such as frequent formal meetings, informal gatherings and activities, and group training and education, there has been improved communication and relationships within MSAs (beyond the core MSA working group). This was particularly prevalent during the COVID-19 response, where MSAs provided information to their members and a safe platform to have open dialogue (e.g., weekly virtual meetings, information bulletins, websites, and email updates).

There was some evidence across the data to suggest that there was improved communication and relationship building within MSAs and that the FEI contributed to this. For instance, findings from SRRP self-assessment forms completed by 51 (77%) facilities, indicated that majority of MSAs rated themselves as having either always or frequently improved engagement between MSA members over the previous year (n=50; 98%). Similarly, nearly two thirds (64%; n=14) of key informants reported that the FEI contributed to improved communication and relationships within MSAs (beyond the core MSA working group) to a great or very great extent, while others (23%; n=5) indicated that the impact in this area was moderate. Results were generally consistent across respondent groups, but MSA project managers were more likely than other respondents (i.e., physicians, EPs, and HA representatives) to report positive impacts in this area. Further, survey

[19] Participation in the FEI was measured by examining provider activity in FEMS (e.g., date joined, account activity). This included MSA members as well as other providers who participated in the FEI (e.g., allied health staff).
[20] University of British Columbia. n.d. Increasing Physician Engagement: Literature Review.

participants (n=156) identified in their qualitative responses that the FEI and/or engagement activities have improved engagement within MSAs by building connections and strengthening relationships among physicians. The following table outlines the factors reported by both key informants and survey participants that improved communication and relationships within their MSAs.

Table 11: Factors That Supported Improved Communication and Relationship Building Within MSAs

Factors	Description
Frequent Formal Meetings	Conducting formal meetings such as frequent MSA meeting as well as other regularly scheduled meetings (e.g., Local Medical Advisory Committee meetings, weekly physician meetings). In 2019-20, MSAs conducted total of 251 formal meetings, with an average of 3.6 meetings annually (ranging from 0 to 12).
Informal Gatherings and Social Activities	Offering spaces and social activities that allow physicians to meet, gather, network, and develop peer supports, particularly in welcoming physician lounges/staff rooms that are stocked with food and beverages (e.g., coffee and snacks) as well as social activities (e.g., outdoor activities, wellness events). This was further noted in physician engagement literature as a common practice to strengthen culture, community, and communication.
Group Training and Education	Providing education and training opportunities that create connections and foster collaboration between specialties and providers, particularly simulations and support for education opportunities through journal clubs and rounds.
Strong MSA Executive Team	Having a strong executive team that is well-liked by peers and therefore more engaging. It was noted that an ineffective MSA executive (e.g., not well-liked by peers) can be a determinant to communication and relationship building. Indeed, supporting high-quality leadership was noted as a common practice in increasing physician engagement in the literature.
Frequent Communication	Communicating often and succinctly to MSA members such as through brief, weekly newsletters to keep members informed and engaged in the work of the MSA. This was further noted in physician engagement literature as a common practice to increase engagement by being visible and available for communication.
Specific Focus on Relationship Building	Emphasizing relationship-building at the early stages of MSA development to build the foundation to successfully work together on project and activities.
Updates on FEI Activities	Conducting word of mouth communications and strategic sharing of the results of FEI funded activities across departments to ensure MSA members as well as others were aware of the work that is occurring. This was further noted in physician engagement literature as a common practice of celebrating successes.

"There's been positive progress and increased engagement since I started and as the FEI has evolved. When I first started, it was hard getting quorum at our MSA meetings. Now we are almost a full house and meetings aren't long enough. People are fully engaged, bring new ideas, and are excited. They feel common support on challenges." – MSA Project Manager

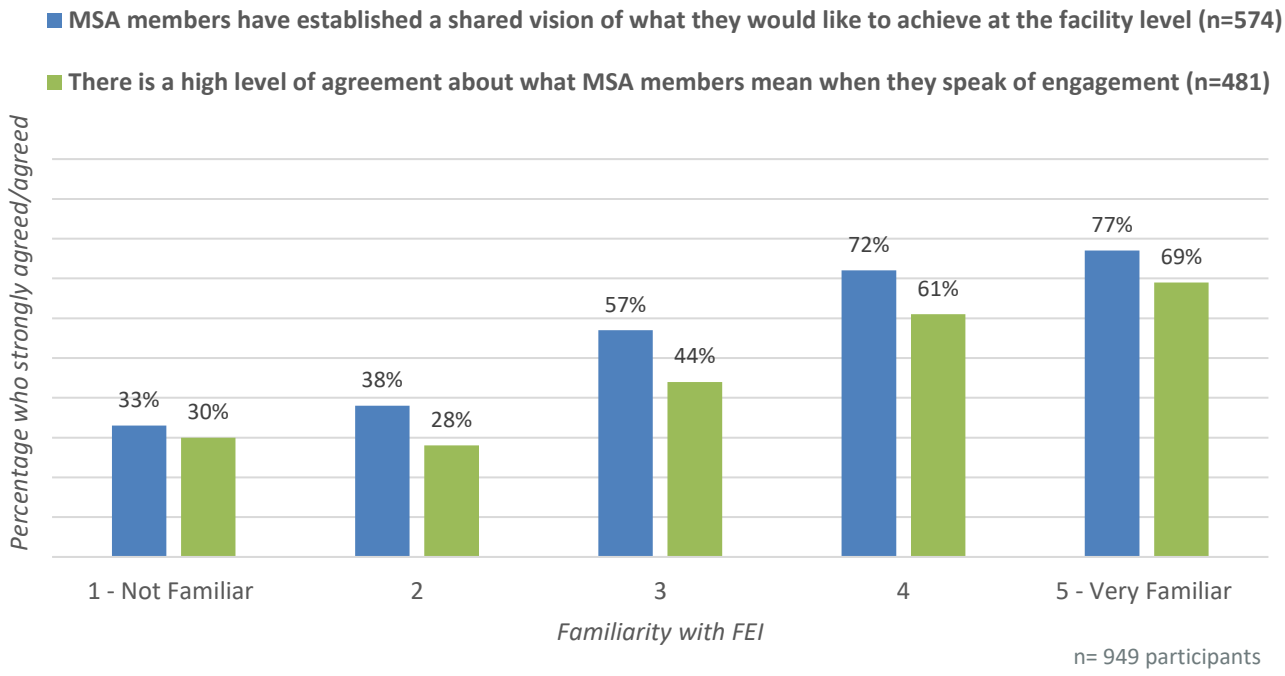
Survey participants (n=159) also noted through qualitative responses that MSAs supported important communication among members – particularly around the COVID-19 response – by providing information and

a safe platform where open dialogue could take place. Various communication methods were utilized including weekly virtual meetings, information bulletins, websites, and email updates.

Preliminary Finding 3: A majority of stakeholders including MSA members and HA leadership and staff reported that MSA members at their facility have established a shared vision and have clarity regarding the meaning of engagement, suggestions positive engagement within MSAs.

A majority of facility-level survey participants including MSA members and HA leadership and staff (n=949) agreed or strongly agreed that MSA members have established a shared vision of what they would like to achieve at the facility level (67%; n=574) and that there is a high level of agreement about what MSA members mean when they speak of engagement (57%; n=481), suggesting some positive communication and engagement within MSAs. Overall, individuals more familiar with the FEI tended to agree more often with these measures, compared to others (figure 8), suggesting some positive effects of the FEI on participants' perception of these engagement measures.[21]

Figure 7: Survey Participants Who Strongly Agreed or Agreed with Statements Regarding Engagement Within MSAs by Familiarity with the FEI, 2020



Creating a shared vision such as defining engagement and identifying shared goals and targets are identified as common practices to increasing physician engagement in the physician engagement literature. Survey results from the interim findings will be compared with findings from the next phase of the evaluation to further assess progress on these indicators, including the influence of the FEI. In addition, survey results from previous evaluations will be incorporated to examine changes across a longer period of time.

[21] Some caution should be used while interpreting these results as there were more participants who were familiar with the FEI compared to those who were not familiar, and tests of statistical significance were not conducted during this phase of the evaluation

Preliminary Finding 4: Although some FEI activities were reported as having supported engagement amongst different MSA facilities (e.g., scaling of quality improvement initiatives, EP knowledge transfer activities), there was a call from stakeholders for more cross-facility activities.

Less than half (45%; n=10) of key informants reported that the FEI contributed to improved communication and relationships amongst MSAs (i.e., different facilities) to a great or very great extent, while more than one quarter (27%; n=6) indicated that the impact in this area was moderate. Some key informants provided evidence of communication amongst MSAs, such as scaling of quality improvement initiatives across facilities (e.g., a patient-controlled pain management initiative that originated at one facility and was later implemented at another), the implementation of regional collaboratives (e.g., the Island Medical Staff Network), and the work of the EPs to share lessons learned and best practices amongst facilities managed. Additional examples provided by the key informants of cross-facility collaboration arose as a result of COVID-19, such as the implementation of monthly HA meeting with MSA executives and others, to discuss COVID-19 on a regular basis and MSA implementation with HA involvement of instant messaging technology to support physician communication (e.g., Slack, WhatsApp).

Early Learnings to Further Support MSA Engagement:

MSA Opportunity: Create opportunities for physicians and providers to meaningfully participate in the work of the MSAs and the FEI (e.g., through increasing awareness and understanding around MSA engagement opportunities)

- There were several suggestions by survey participants through their qualitative responses to support further participation of MSA members by increasing outreach and awareness about engagement opportunities among medical staff (n=32), clarifying the work of the FEI and engagement activities (n=30), as well as clarifying the MSA's role and structure in engagement (n=16). Further, there were a few suggestions from survey participants (n=11) to increase opportunities for medical staff to participate in the work of MSAs (e.g., creating roles, identifying tasks, etc.), which was also noted as a common practice for improving engagement in physician engagement literature.

Program and MSA Opportunity: Support more information sharing and relationship building across facilities through regional events spearheaded by the provincial office as well as through improvements to existing knowledge sharing platforms (i.e., SEAT, SRRP).

- Some key informants indicated that there are opportunities for the FEI to further support information sharing and relationships across facilities, such as through regional events spearheaded by the provincial office and improvements to existing knowledge sharing platforms (i.e., SEAT database).

Evaluation Opportunity: Identify lessons learned from the pandemic regarding engagement amongst MSAs and opportunities to leverage these learnings.

- Data regarding engagement amongst MSAs were limited in comparison to other expected outcomes of the program. The next phase of the evaluation will further assess engagement amongst MSAs and identify opportunities to improve engagement amongst MSAs will be explored, including lessons learned from the pandemic.

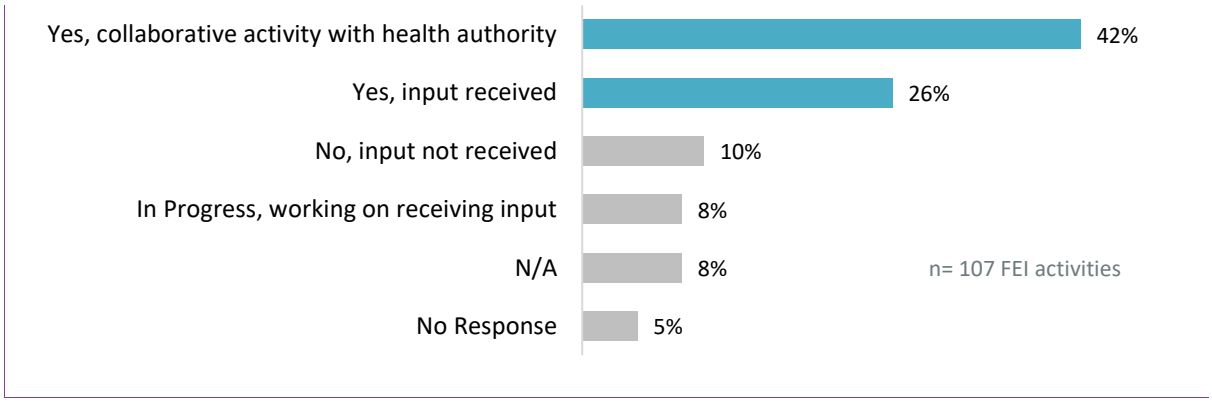
Expected Outcome 3: To what extent has the FEI helped to improve engagement between MSA members and HA representatives, both at the facility level and the broader regional HA level?

One of the key outcomes of the FEI is to contribute to improved engagement between MSAs and HAs. This was assessed by examining HA involvement in FEI activities, levels of engagement occurring between MSAs and HAs at the facility level and regional level (i.e., regional HA level), and increased prioritization of shared issues and decision making between MSAs and HA.

Preliminary Finding 1: A majority of FEI activities involved HAs in some capacity, either through consultation activity (e.g., providing input and feedback on draft solutions or strategies) or to a greater extent, collaborative activity (e.g., working together to identify a preferred solution or strategy) with MSAs, including activities related to COVID-19.

As illustrated in Figure 9 below, an analysis of the representative sample of FEI activities (n=107) from the SEAT database demonstrated that a majority of activities entailed HA involvement (68%; n=73). Smaller proportions (8%; n=8) were in the process of receiving HA input at the time of data extraction or indicated that HA input was not applicable to the activity (8%; n=8). Some (10%; n=11) activities did not receive HA input, although no rationale or additional details were provided, and no patterns were identified in the data to identify unique characteristics of activities that did not receive HA input. In addition, findings from the SRRP self-assessment forms completed by 51 (77%) participating facilities indicated that 88% of these MSAs consult with HAs on proposed activities (where required). As data is limited at this time, this will be further analyzed in the next phase of the evaluation.

Figure 8: MSA Engagement of HA in a Sample of FEI Activities, Jan 2018 to May 2020



More than half of key informants (55%; n=12) reported that the FEI activities increased opportunities for engagement between MSAs and HAs to a great or very great extent, while nearly one third (32%; n=7) indicated that the impact in this area was moderate. Several key informants across all respondent groups described that the FEI created space and time for MSAs and HAs to work collaboratively to address issues of concern or interest, such as through the MSA working group meetings.

In fact, in 2019-20, most (80%; n= 56) MSA working groups extended a standing invitation to the HA to attend their meetings or had standing meetings between the MSA Executive and the local HA partners to discuss activities. This was consistent across the regions (i.e., Island, Northern, Interior and Lower Mainland). For the MSAs that didn't regularly engage HAs (20%; n=14), reasons included that engagement of HAs was in progress at the time of the evaluation, the MSA did not hold regular meetings, and that HAs are not invited to the Working Group meetings specifically but they are engaged through other processes (e.g., a standing monthly meeting with the Project Manager, MSA president, and facility director).

> *"We aren't there yet but there's been a huge improvement. A lot of the HA partners still feel they meet with us because they have to. It should be that we are meeting to accomplish goals together. There's quite a bit of variability but the FEI has helped a lot."* – Physician

Level of Participation of HAs in FEI Activities

To better understand the involvement of HAs in the sample of FEI activities (n=107), activities were examined using the IAP2 framework for public engagement. The FEI adopted the IAP2 to provide a clearer definition for engagement to MSAs and HAs. As illustrated in Figure 10 below, the original framework was adapted slightly by the FEI to remove the "involve" category, as program stakeholders indicated through consultations that the meaning of the category was unclear.

Figure 9: FEI Adapted IAP2 Framework

	INFORM /EDUCATE	CONSULT	COLLABORATE	EMPOWER
GOAL OF ENGAGEMENT	Medical staff and Health Authority (HA) provide one another with objective information of each partners' activities.	Medical staff and HA consult with one another on draft plans, and feedback received has influence on decision-making.	Medical staff and HA partner collaborate in each aspect of the decision, including the development of alternatives and the identification of the preferred solution / strategy.	Medical staff and HA are equal partners in final decision-making.
	INCREASING LEVEL OF COMMITMENT			
PROMISE TO STAKEHOLDERS	Stakeholders will be informed throughout the activity of changes and progress.	Stakeholders will be informed, listened to and their concerns acknowledged. Feedback will be provided on how their input influenced the decision.	Stakeholders' advice and recommendations will be incorporated into decisions to the maximum extent possible.	Stakeholders' decisions will be implemented.

Based on the definitions of the IAP2 categories included in the FEI framework above (i.e., inform/educate, consult, collaborate, and empower), nearly one quarter (23%) of sample SEAT activities fell within the "consult" category, where MSAs and HAs consulted with one another on draft plans, and feedback received had influence on decision making. For example, for some activities HAs provided verbal or written support for project initiation at the outset (e.g., through the SRRP) or were invited to attend planning meetings for information and feedback purposes.

Additionally, nearly half (42%) of sample SEAT activities aligned to the "collaborate" category, where MSAs and HAs collaborated in each aspect of the decision, including the development of alternatives and the

identification of the preferred solution or strategy. For example, several activities included HA representatives as active participants in the working groups that informed the project or activity. For others, some event-related activities had HA representatives involved in planning and hosting roles. These findings indicate that, as of May 2020, many of the FEI activities entailed a moderate to advanced level of stakeholder participation.

HA Participation in COVID-19 Related FEI Activities

Based on a representative sample of 42 entries selected from the COVID-19 Activity Tracker,[22] more than half (57%; n=24) of COVID-19-related activities entailed HA participation. The types of FEI COVID-19 activities occurring with HA involvement are outlined in the table below.

Table 12: HA Involvement in a Sample of COVID-19 Related FEI Activities

Activities	Description
Meetings (n=13)	COVID-19-related meetings were often spearheaded by HAs or involved collaboration with HA representatives given the nature of the meeting topics (e.g., Emergency Outbreak Committees, relocation of existing clinics to free up hospital space for COVID-19 patients)
Communication (n=4)	COVID-19 related communication activities often involved HA support or buy-in, for example to receive approval for physician communication via instant messaging platforms (e.g., WhatsApp, Slack).
Training (n=4)	All COVID-19-related training that occurred with HA involvement was simulation training (e.g., safe technique of donning and doffing of enhanced PPE, intubation training simulations)
Meals (n=3)	Food and beverages made available in physician lounges during COVID-19 were also available to HA staff.

It was difficult to categorize the sample activities along the IAP2 continuum given the highly qualitative nature of the information and variable level of detail included. However, based on descriptions it appears that many activities (particularly meetings) involved direct collaboration with the HAs in order to respond to the pandemic.

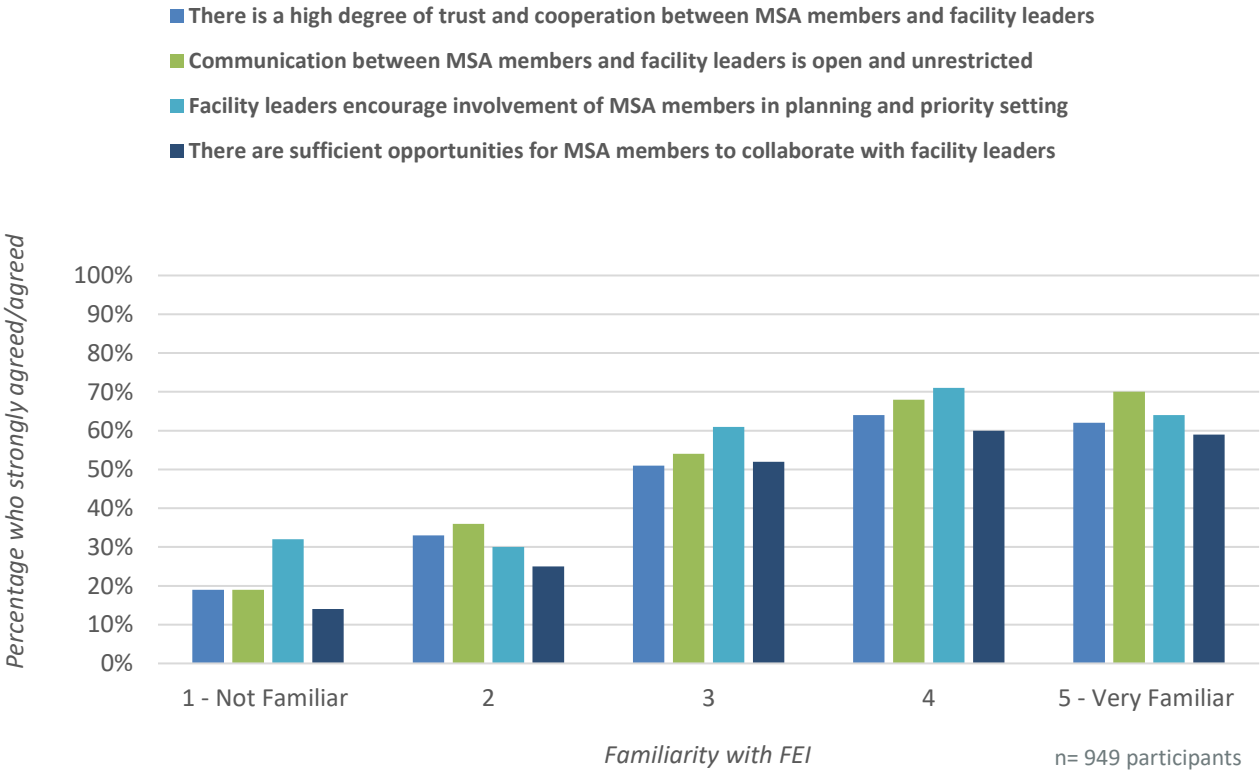
Preliminary Finding 2: Through the support of FEI structures and processes (e.g., project management and administrative support, standing invitations or meetings between MSA working groups and HA representatives), MSAs and HAs are engaging with one another. This was particularly true for stakeholders at the facility-level, where a majority of MSA members and HA leadership and staff indicated there was trust, cooperation, open communication, as well as encouragement and opportunities for collaboration between MSA members and facility-level HA leaders.

Survey findings suggest that there has been some positive engagement between MSA members and facility-level leaders (also referred to as facility leaders). On average, approximately half (52%; n=494) of facility-level survey respondents including MSA members and HA leadership and staff (n=949) agreed or strongly agreed with statements measuring engagement between MSA members and facility-level leaders (figure10). Interestingly, participants more familiar with the FEI tended to report greater engagement between MSA members and facility-level leaders compared to those who were less familiar. Indeed, survey participants

[22] To support representativeness, activities were first categorized by HA, funding tier, status (i.e., on hold, in progress, complete, no status assigned), and whether the activity received FEI funding and then a random sample was selected across these categories.

(n=40) in their qualitative responses identified that FEI funding and other structures (e.g., administrative support, project management) supported MSAs and HAs to collaborate on engagement initiatives.

Figure 10: Survey Participants who Strongly Agreed or Agreed with Statements Regarding Engagement Between MSA Members and Facility-Level Leaders by Familiarity with the FEI, 2020

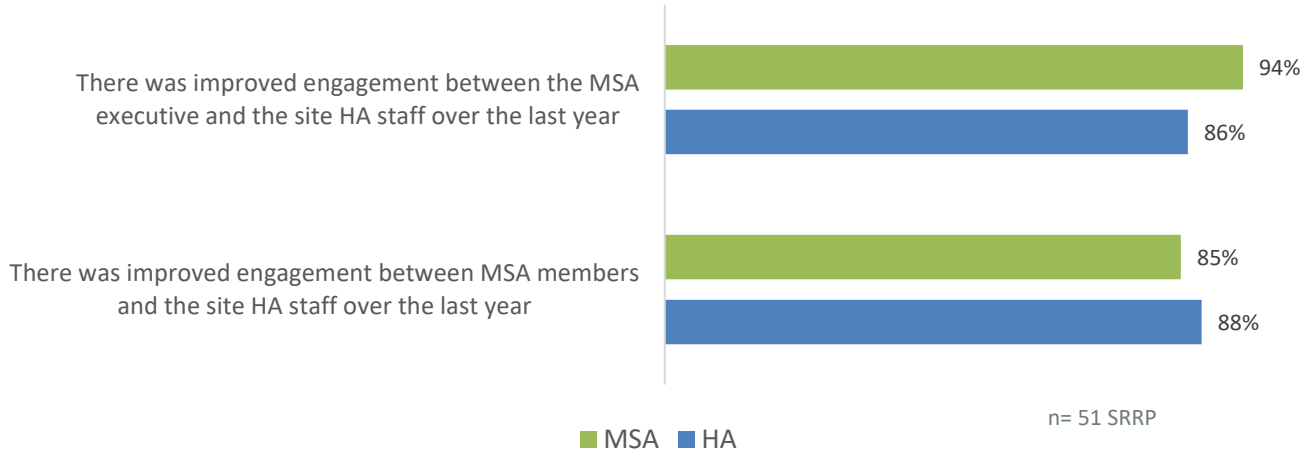


Some differences were also seen between leadership status, where facility-level leaders tended to have a greater average agreement on these measures of MSA and HA engagement (70%; n=108) compared to non-leaders (56%; n=377). Further, there were differences across HAs, some of which routinely received more or less favourable ratings for relationships and engagement between MSAs and HAs. For example, respondents from VIHA and PHSA tended overall to have the lowest levels of agreement regarding MSA and HA engagement, while IHA and Providence tended overall to have the highest levels of agreement. Facility-level engagement will be further examined in the next phase of the evaluation including an examination of 2020-21 data collection on the same measures as well as a deeper analysis of those who had less positive views.

In addition, findings from the SRRP self-assessment forms completed by 51 (77%) participating facilities suggested that there has been improved engagement between MSAs and HAs specifically over the past year (figure 12). In particular, MSAs and HAs rated themselves as either always or frequently having improved engagement between MSA members and the facility HA staff over the last year (88% and 85%, respectively) and improved engagement between the MSA executive and the facility HA staff over the last year (85% and 94%, respectively). In addition, MSAs and HA rated themselves highly on other measures of engagement. MSAs indicated that they consulted with HAs on proposed activities (where required) (88%) and HAs identified that they offered appropriate opportunities and time for MSAs to effectively engage in plans and initiatives

(82%) with the HAs and to a lesser extent, had effective structures and processes in place for MSAs and HAs to consult and collaborate on priorities (79%).

Figure 11: Percentage of High Scores on Self-Assessment Forms for Statements Regarding Facility-Level Engagement between MSAs and HAs, 2019-20



Facility-level Communication and Relationship Building Between MSAs and HAs

Through their qualitative responses, facility-level survey participants identified that the FEI has helped to develop and strengthen relationships between stakeholders (n=266), including improving relationships and collaboration between MSA members and HA staff (n=56). This was primarily through collaborative initiatives as well as processes and structures that supported communication, connections, and input at the facility-level. Positive examples included MSA membership on HA committees and meaningful consultation in planning and decision-making (e.g., in the redesign of St. Paul's Hospital, in COVID-19 response planning and implementation).

Similarly, half of key informants (50%; n=11) reported that the FEI has contributed to increased communication and relationships between MSAs and HAs to a great or very great extent, and over one third (36%, n=8) indicated that the impact in this area was moderate. Several key informants indicated that the FEI has been effective at providing a forum for MSAs and local HA partners to convene on key topics of interest, and some reported that there has been a significant improvement in interactions between MSAs and local HA partners since program implementation. Further, a few key informants reported that the FEI facilitated effective two-way communication channels during COVID-19, as relationships and connections had been previously established as a result of the program, which allowed for a more effective pandemic response.

There was some indication from HA respondents that communications with physicians are made more challenging due to limited physician use of HA email addresses, which makes it difficult for HA staff to contact physicians in an efficient manner. A key example of this was the Better Use of VIHA Secure Email activity which aims to address IT barriers to improve communication, relationships, and patient Care. Additional information regarding this example is provided in the activity highlight box below.[23]

[23] Additional information about this activity can be located in the accompanied Collective Story Report.

ACTIVITY HIGHLIGHT BOX: BETTER USE OF VIHA SECURE EMAIL

Location: VIHA | **Timing:** Started May 2020 (ongoing)

Description: A physician-led initiative to reduce the amount of unwanted emails sent to physicians' HA email addresses and to improve access to email

Objectives: 1) To lower barriers to physicians utilizing secure HA email to increase use and 2) ultimately improve patient care through faster and easier communication and coordination between clinicians

Funded: Sessional funding, food, project management support

Outcomes:

Supported engagement among physicians

Trialing and promoting the email filter system among physicians provided an opportunity for physicians to engage with each other about facility and health system improvements.

Increased communication between physicians and health authority staff

This activity spurred the Physician Lead to consult VIHA's privacy and communications departments and communicate with the IMIT department to implement the email filter and plan future IT work, building relationships with health authority staff. The HA's willingness to address an issue of importance to physicians also supported relationship-building by demonstrating openness and responsiveness to physician input.

"If they [the health authority] *can demonstrate that they are trying, then they are symbolically saying, "We want to work together with you* [physicians]*." I think that's pretty valuable."*

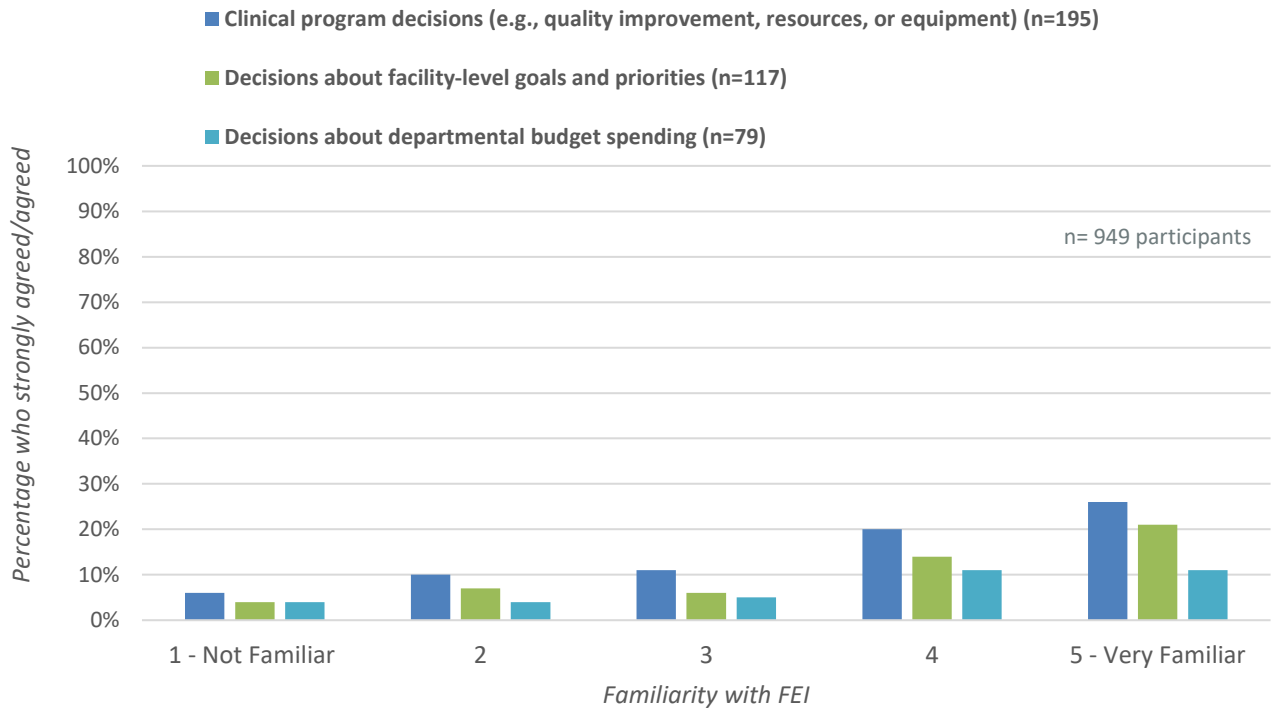
Evaluation findings indicated that communication and relationship building were important for the development of within MSA engagement. The next phase of the evaluation will further assess communication and relationship building between MSAs and HAs at the facility-level, including opportunities to foster components of engagement.

Preliminary Finding 3: At the facility-level, there was less agreement from stakeholders regarding their level of influence over the prioritization of issues and decision making, where very few survey respondents believed they had much influence over clinical program decisions, site-level goals and priorities, or decisions about departmental budget spending. There were several suggestions to formalize consultation and engagement processes and structures to ensure meaningful collaboration between MSAs and HAs.

Ultimately, the FEI goal of contributing to increased engagement between MSAs and HAs is to support MSAs in having some influence over the prioritization of issues as well as decision making at their respective facilities. Less than half of key informants (45%, n=10) reported that the FEI increased shared prioritization of issues between MSAs and HAs at the facility-level, while nearly one third (32%, n=7) indicated that the impact in this area was moderate. A few key informants (particularly physicians and MSA project managers) indicated that a culture shift towards shared prioritization of issues will take time to implement, given historical silos between physicians and HAs. However, several key informants described improvements to the shared prioritization of issues by MSAs and HAs since FEI implementation, as a result of structures (e.g., working group meetings) and processes (e.g., SRRP, funding applications) which have facilitated communications and prioritization of issues particularly at the local facility-level.

Facility-level survey participants including MSA members and HA leadership and staff (n=949) were asked to rate their agreement with their level of influence regarding decisions made at their facilities. Overall, few participants believed they had much influence (e.g., meaningful input and consultation) over clinical program decisions (19%; n=195), facility-level goals and priorities (13%; n=117), and decisions about departmental budget spending (9%; n=79). Similar to previous survey findings, individuals more familiar with the FEI tended to report greater influence over facility-level decisions (figure 13).

Figure 12: Survey Participants who Strongly Agreed or Agreed with Statements Regarding Their Influence Over Facility-Level Decision Making by Familiarity with the FEI, 2020



Across participant sub-groups, there was greater perceived influence among formal leaders than other respondents, as would be expected. Further, perceived influence was greater for individuals without clinical experience (likely HA leadership and staff) but was also higher for providers who had more clinical experience. There was also a considerable difference in perceived influence across HAs, with a noticeably lower proportion of respondents from IH, PHSA, and VCH reporting strong influence than in other HAs. For example, NHA had higher proportions of respondents identifying influence (perhaps due to smaller facilities).

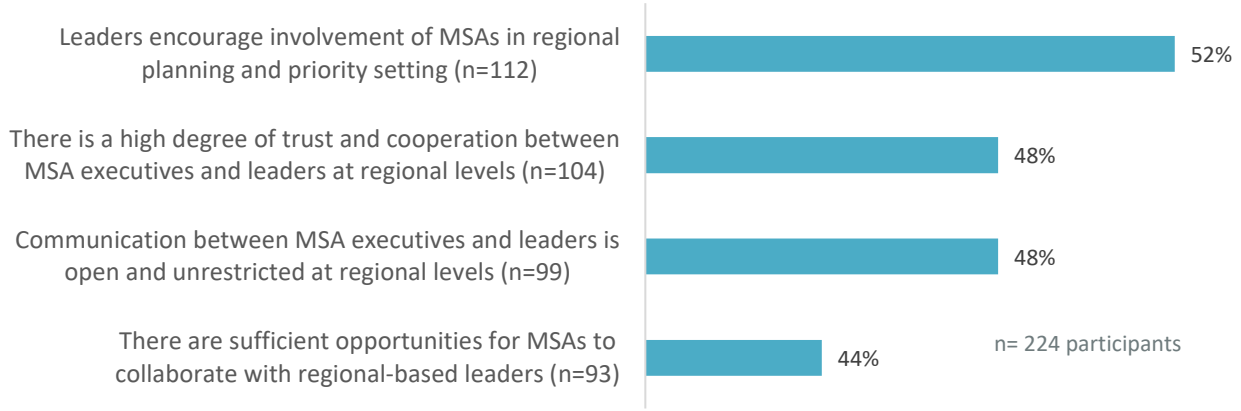
Through their qualitative responses, survey participants indicated that there has been increasing leadership openness to, and support for, physician input (n=31) through engagement and relationship building. Nonetheless, many suggested that there is room to further empower physicians and build their influence (n=48) as well as increase support and buy-in among HA leaders for MSA members to be meaningfully consulted and involved in planning and decision-making rather than being informed or consulted as a formality only (n=42). There were several suggestions to formalize consultation and engagement processes and structures to ensure meaningful collaboration between MSAs and HAs.

Comparisons in reported influence will be assessed over time though subsequent administration of the province-wide survey as well as qualitative interviews during the next phase of the evaluation. In addition, opportunities for greater prioritization of issues and influence over decisions with be explored.

Preliminary Finding 4: There was also less agreement among stakeholders with regional HA administrative roles and/or MSA executive roles regarding MSA and HA engagement at the regional HA level. There was a common interest for greater regional HA engagement with MSAs to ensure ongoing collaboration and communication and support strategic planning and implementation of initiatives.

Survey participants with a regional HA administrative role and/or MSA executive role (n=224) were asked to rate their agreement with statements relating to regional engagement between MSAs and HAs (i.e., engagement across VIHA, NHA, IHA, VCH, FHA, and PHSA)). On average, approximately half (48%; n=102) agreed with the statements outlined in the figure below regarding MSA and HA engagement at the regional level (i.e., trust, open communication, involvement, collaboration). This was slightly less than the average agreement reported regarding facility-level engagement between MSAs and HAs (59%; n=494). Physician MSA members were also less likely to agree with statements about regional engagement between the MSA and HA compared to non-MSA respondents such as HA leadership.

Figure 13: Survey Participants who Strongly Agreed or Agreed with Statements Regarding MSA and HA Regional Engagement, 2020



Through their qualitative responses, survey participants identified a common interest in increasing coordination and alignment between facilities, regions, and/or initiatives (n=35), recognizing there is a lot of interrelated quality improvement and engagement work at all levels. For instance, survey participants expressed interest in learning from others (e.g., physicians at other facilities), reducing differences between the regions in terms of engagement activities and quality improvement projects, and avoiding duplication of work, particularly by increasing the amount of regional engagement and initiatives.

Similarly, some key informants, particularly physicians and HA representatives, reported that while engagement has primarily improved at the local facility level, there is an opportunity for greater regional HA engagement with MSAs to ensure ongoing collaboration and communication and support strategic planning and implementation of initiatives. An example of efforts to support regional collaboration undertaken by one

HA was the implementation of regional tables that bring together representatives of various funding streams to determine how best to support provider-led initiatives.

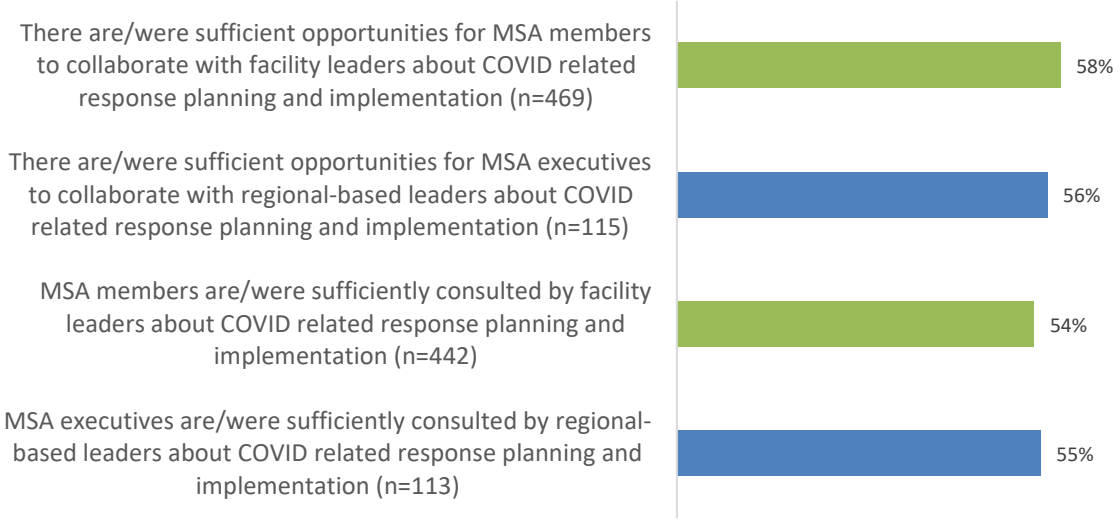
> *"We are encouraging regional tables to meet across different funding streams to determine how to vet and support physician projects. Every single initiative has slightly different rules so how can we get the best out of these projects? Some bigger issues are region-wide, and we need to be able to take a strategic look at how we do things."* – HA Representative

Preliminary Finding 5: FEI structures and processes supported enhanced consultations and collaboration between MSAs and HAs related to response planning and implementation for the COVID-19 pandemic (e.g., physician group consultations with facility leaders, regular meetings with facility leadership and MSAs, and collaborative departmental planning).

In addition to FEI structures and processes supporting responses to COVID-19 (including improved engagement within and amongst MSAs), the evaluation found that the FEI also supported improved engagement between MSAs and HAs to respond to the pandemic. In particular, data suggests that the FEI supported enhanced consultations and collaboration related to response planning and increased prioritization of issues and effective communications between MSAs and HAs, both locally and regionally.

A majority of facility- and regional-level survey participants agreed or strongly agreed that there were opportunities for MSA members to collaborate with leaders regarding COVID-19 response planning and implementation at both the facility-level (58%; n=469) and the regional level (56%; n=115) (figure 15). In addition, these same participants agreed or strongly agreed that they were sufficiently consulted by leaders at both the facility-level (54%; n=442) and regional levels (55%; n=113).

Figure 14: Survey Participants who Strongly Agreed or Agreed with Statements Regarding MSA and HA Engagement Related to COVID-19 Response Planning and Implementation, 2020



n=949 site-level participants
n=224 regional participants

Importantly, physicians and non-MSA members (e.g., HA staff) were equally as likely to agree that there was sufficient collaboration and consultation at the facility-level. Further, through their qualitative responses, survey participants (n=223) reiterated that there had been physician consultation, input, and involvement in planning and decision-making, particularly in response to COVID-19. For instance, participants noted that there have been physician group consultations with facility leaders, regular meetings with facility leadership and MSAs, and collaborative departmental planning. A much smaller number of respondents (n=27) reported that there was room for improvement regarding engagement and consultation (e.g., greater MSA involvement in decision making).

> *"The level of engagement we saw from physicians with COVID-19 planning, we won't forget that. I think it has become the way of the future. The level of collaboration with administration was unprecedented. We will continue to push for that going forward."* – Physician

In addition, several key informants across all respondent groups (i.e., physicians, HA representatives, MSA project managers, and EPs) cited COVID-19 as a positive example of shared prioritization of issues, as both MSAs and HA partners convened on a regular basis for collaborative planning and pandemic response. An example provided by one key informant of a structure developed for shared prioritization of issues during the pandemic was the FHA Presidents Council, which gathers every two months with HA representatives. The Council was described as a forum where MSAs and HAs could look at what is happening across FHA to and communicate priorities related to the pandemic response. Another example of shared prioritization and collaborative planning was the implementation of virtual health to improve in-patient care during COVID-19, which is further described in the activity highlight box below.[24]

ACTIVITY HIGHLIGHT BOX: 2020 COVID RESPONSE - VIRTUAL HEALTH

Location: Royal Columbian Hospital, FHA | **Timing:** Started March 2020 (ongoing)

Description: A physician-led initiative to increase use of virtual technology in an in-patient setting, particularly during COVID-19, to support standardized advanced care planning, reduce contact between patients and staff, and increase communication between patients and family members

Objectives: 1) To support physicians to work and manage patients in a safe environment and 2) provide the best patient care in a pandemic setting

Funded: Sessional funding, education, video production

Outcomes:

Improved delivery of safe and supportive patient care

Limiting the number and duration of patient-provider contacts by using virtual technologies when in-person care was not required mitigated exposure to COVID-19 while maintaining quality of care. The technology also reduced

Strengthened relationships between providers and the HA

Engaging regularly with HA staff to get project approval and support the roll out the project (e.g., address technical and logistical challenges) allowed providers to learn about key players and processes in the HA and engage meaningfully in

Supported health system optimization and innovation

Engagement supported novel and rapid implementation of virtual technologies in an in-patient setting, resulting in reduced PPE usage and prompting innovative thinking among providers. For example, providers quickly identified

[24] Additional information about this activity can be located in the accompanied Collective Story Report.

isolation by enabling patients to safely connect with friends and family, improving wellbeing.	planning and decision-making conversations.	broader applications for the technology, particularly around patient education.

"For the first time, as a result of COVID, we were having consistent, open conversations with admin about policies and procedures... We really focused our efforts on developing relationships in the health authority to ensure that these virtual technologies could be integrated – to make sure it was feasible and making sure there was support from those that needed to support it."

Early Learnings to Further Support MSA and HA Engagement:

Program and MSA Opportunity: Encourage buy-in among HA leaders to formalize consultation and engagement processes to support meaningful collaboration between MSAs and HAs, particularly during early planning stages.

- A few key informants said there are ongoing challenges at some facilities engaging stakeholders to the extent required for ongoing project delivery, particularly at the larger facilities, and a small number indicated that there could be greater reciprocity in engagement efforts (e.g., some MSAs feel they reach out more to the HA than vice versa). Difficulties securing HA involvement and buy-in on individual projects was noted by a small number of key informants (physicians and MSA project managers) as a barrier to ongoing project delivery. Key informants suggested that there is an opportunity for the SSC to continue to encourage HA partners to meaningfully engage with the program, particularly at the early stages of project planning and delivery, with greater consistency.

MSA and HA Opportunity: Explore additional options to increase regional MSA and HA engagement to encourage learning from others (e.g., from physicians at other facilities) and avoid duplication of work.

- Through their qualitative responses, survey participants identified a common interest in increasing coordination and alignment between facilities, regions, and/or initiatives (n=35), recognizing there is a lot of interrelated quality improvement and engagement work at all levels. Some examples of promising practices identified during the evaluation included the FHA MSA Presidents council, which gathers every two months with HA representatives as well as the regional tables that are bringing together representatives of various Doctors of BC funding streams (beyond FEI) to collaborate on how best to support provider-led initiatives.

Evaluation Opportunity: Identify lessons learned from the pandemic regarding engagement between MSAs and HA, both at regional and local levels, and opportunities to leverage these learnings in other areas of the initiative.

- Engagement between MSAs and HAs in the context of the COVID-19 pandemic response will be further explored in the next phase of the evaluation, including an examination of the facilitating factors which supported increased engagement and the opportunities to apply these lessons to other areas of the FEI, beyond the pandemic. Interestingly, key informants at some facilities indicated that work is already underway to determine how the effective engagement processes implemented as part

of the COVID-19 response can be sustained going forward. The evaluation could be a good opportunity to gather this facility-level data and bring forward learnings at a provincial level.

Expected Outcome 4: To what extent has the FEI helped to enhance the collective voice of MSA Members in health system planning and decision-making?

One of the key outcomes of the FEI is to contribute to enhanced MSA collective voice in health system planning and decision making. This consists of meaningful MSA consultation into regional and site 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, and alignment between MSAs and existing HA structures (e.g., medical advisory committees).

The theory of change for the FEI program identifies that with improved engagement within and amongst MSAs as well as improved engagement between MSAs and HAs, enhanced MSA collective voice in health system planning and decision making can occur. Evaluation findings noted above identified that there has been some improved engagement between stakeholders (e.g., collaboration and consultation), particularly at the facility-level, supported by the establishment of FEI structures and processes (i.e., financial and administrative supports, formal and informal opportunities to gather and collaborate on a regular basis, etc.). However, there is also some data to suggest that more work is needed to enhance the MSA collective voice, at both the site and regional levels.

Preliminary Finding 1: At the facility-level, there is evidence to suggest that MSAs represent the priorities and collective interests of their members and that participating in MSA activities has helped to address issues of importance to members, suggestive of some collective voice occurring. However, stakeholders such as MSA members and HA staff largely did not feel sufficiently consulted by facility-level leaders about initiatives and processes that directly impact their work environments or patient care, a key component of enhancing MSA collective voice.

A majority of facility-level survey participants including MSA members and HA leadership and staff agreed or strongly agreed that MSAs represent the priorities and collective interests of their members (n=713/949; 80%) and that participating in MSA activities has helped address an issue of importance (n=513/723; 74%). However, much fewer agreed or strongly agreed that MSA members are sufficiently consulted by facility-level leaders about initiatives and processes that directly impact their work environments and/or patient care (n=347/949; 42%), suggesting room for improvement regarding facility-level collective voice. Similar to other findings in this report, there were greater levels of agreement with increasing FEI familiarity. Further, considerably more facility-level MSA and HA leaders reported sufficient consultation about facility initiatives and processes than did non facility-level HA leaders, highlighting differences in perceptions between roles.

Similarity, less than half of key informants (41%, n=9) indicated that the FEI contributed to enhancing the MSA collective voice in health system planning and decision-making to a great or very great extent, and slightly more than one-third (36%, n=8) felt the impact in this area was moderate. Several key informants cited the forum provided by the FEI for physicians to convene on issues of particular interest or relevance to their communities as the key facilitator of the program in enhancing MSAs' involvement in health system change.

Preliminary Finding 2: A majority of stakeholders with a regional HA role or MSA executive role indicated that MSA executives have established a shared vision and that working with MSA representatives has helped to address an issue of importance to them. However, almost two thirds of these stakeholders did not feel sufficiently consulted by regional-based leaders about initiatives and processes that directly impact their work environments or patient care, a key component of enhancing MSA collective voice.

A majority of survey participants with a regional HA role or MSA executive role agreed or strongly agreed that MSA executives have established a shared vision of what they would like to achieve at regional levels (n=125/224; 59%) and that working with MSA representatives has helped address an issue of importance (n=74/97; 77%). However, similar to the facility-level participants, fewer regional participants agreed or strongly agreed that MSA executives are sufficiently consulted by regional-based HA leaders about initiatives and processes that directly impact their work environments and/or patient care (n=74/224; 35%), suggesting room for improvement on this measure of collective voice. These findings were consistent with previously noted data regarding MSA and HA engagement at a regional level, suggesting regional engagement and regional collective voice need further attention.

According to a few key informants, examples of FEI-funded initiatives that have helped to enhance MSAs' collective voice include the East Kootenay Patient Transportation Committee and the VCH Wellness, Diversity, and Equity Committee, both of which were regional initiatives involving multiple MSAs and stakeholder groups. The activity highlight box below provides additional detail on the East Kootenay Patient Transportation Committee, which is addressing rural patient transport challenges through regional, multi-stakeholder collaboration.[25]

ACTIVITY HIGHLIGHT BOX: EAST KOOTENAY PATIENT TRANSPORTATION COMMITTEE

Location: East Kootenay, IHA | **Timing:** Started Fall 2018 (ongoing)

Description: Formed a regional working group to bring stakeholders such as physicians, MSA, HA representatives, BC Emergency Health Services, and the provincial government together to collectively examine and address challenges with patient transport in a rural setting

Objectives: 1) To improve the patient transport experience for local physicians and 2) build relationships between smaller sites and the regional centre

Funded: Sessional funding, food, project management support

Outcomes:

[25] Additional information about this activity can be located in the accompanied Collective Story Report.

Strengthened relationships between health system partners

The Committee creates linkages between members and is a good venue for sharing information and building understanding. For example, Committee meetings provided an opportunity for a representative from BC Ambulance Services to discuss Patient Transfer Network decision-making processes and address questions and concerns.

Increased physician engagement and capacity

Providing a forum and funding support for physicians to participate has been motivating for participants, as has the willingness of all partners to address issues of importance to physicians. The initiative also provides physicians with opportunities to develop and implement leadership skills, such as by engaging local leaders about health system issues.

Established a collective voice

The Committee has come to be seen as the key body to engage regarding patient transportation in the region. For example, there has been two-way communication and information-sharing between a provincial lead and the Committee. The Committee has also presented to Island Health and at a provincial conference.

"That's the good thing about FEI – it gets the physicians to show up. If physicians don't show up, decisions get made without them."

Preliminary Finding 3: During the COVID-19 pandemic, FEI structures and processes supported MSAs in becoming more involved in health system change. In particular, with FEI support, physicians participated alongside HA partners in more leadership roles during the pandemic that had some influence over health system planning and decision making including COVID-19 working groups and Emergency Outbreak Committees.

Through their qualitative responses, survey participants (n=87) indicated that the FEI and engagement activities more broadly have helped to increase physician leadership by supporting opportunities and roles to develop leadership skills (e.g., leading a project) and increasing interest in leadership positions. This included physician participation in advocacy and leadership roles during COVID – for instance, physicians participated on leadership committees and groups, including COVID-19 Working Groups and Emergency Outbreak Committees, with FEI support. Survey participants also indicated that FEI and engagement activities have helped to amplify and unify the voice of physicians (n=15). For example, FEI has supported different departments and MSAs to communicate and collaborate to discuss and align plans and priorities, including around COVID-19.

A small number of key informants reported that some facilities are in the early development stages so have not yet demonstrated impacts in this area of collective voice, or that poor relationships between MSAs and administration have inhibited meaningful involvement of MSAs in planning and decision making.

Early Learnings to Further Support MSA Collective Voice:

Program, MSA, and HA Opportunity: Similar to previous areas of opportunities, encourage HAs to involve physicians in systems-level discussions and decisions at the outset, but at the same time provide physicians with more knowledge of the health system to improve awareness and understanding of their role so that they can engage effectively.

- Feedback provided by a few respondents to improve MSA involvement in health system planning and decision making was to increase the onus of HAs to involve physicians in systems-level discussions and decisions at the outset and to increase physician knowledge of the health system to improve awareness and understanding of their role (e.g., roles and responsibilities of HAs and Ministry of Health).

Evaluation Opportunity: Continue to examine facilitators which support MSA collective voice at the facility and regional levels and identify lessons learned from the pandemic and opportunities to leverage these learnings in other areas of the initiative.

- The next phase of the evaluation will further examine the facilitators which support MSA collective voice and opportunities to enhance this at the facility-level. In addition, the next phase will further examine regional activities to identify the mechanisms that were established to enable regional engagement and support perceptions of MSA collective voice at the regional level.

Expected Outcome 5: To what extent has the FEI enabled MSA Members to impact the quality of patient care in BC?

One of the intended impacts of the FEI is to enable MSAs to impact quality of patient care. The BC Health Quality Matrix defines quality of patient care in terms of quality dimensions such as care that respects the patients' choice and safety, services that are accessible and appropriate to the patients' context, effective care that achieves intended outcomes, and efficient use of resources and equitable resources distribution for the needs of a population.

Preliminary Finding 1: Over half of FEI activities examined addressed a quality dimension from the BC Health Quality Matrix (e.g., improving the appropriateness of services to the patients' context, improving the efficient use of resources), suggesting the FEI is supporting MSAs to impact quality of patient care.

The SEAT database collected data on certain quality dimensions from the BC Health Quality Matrix including access, appropriate/effectiveness, efficiency, and safety. Based on the sample of SEAT entries (n=107), a majority (n=63; 59%) addressed at least one quality dimension outlined in the BC Health Quality Matrix. The specific breakdown of quality indicators across the sample SEAT activities is outlined in the table below, along with examples of the activities.[26]

[26] SEAT entries can be coded by multiple quality dimensions, so the total number of indicators (n=110) is greater than the total number of activities identified as having addressed dimensions (n=63)

Table 13: Quality Dimension Identified for a Sample of FEI Activities

Quality Dimension	Number/ Percentage	Examples
Appropriate/ Effectiveness	n=40 (30%)	• Pediatric Eating Disorder Clinic Planning Project • Reducing contamination rates of catheterised urine samples in neonates admitted to Neonatal Intensive Care Unit (NICU) using team-based quality improvement approach • Infectious Disease Education Session
Efficiency	n=30 (23%)	• Mission Hospital ER Flow Improvement • Clinical Simulation Project in Sechelt ER • Focus groups to gain a deeper understanding of how BC Cancer supportive cancer care services can be improved from the medical/physician perspective
Access	n=21 (16%)	• Physician and Allied Health Staff Recruitment and Retention Working Group • Extension of Radiology Services after working hours • A Maternity Program Review to improve access to midwifery care
Safety	n=19 (14%)	• Review of workplace safety mechanisms, including narcotics location and storage and security issues in the hospital • COVID-19 response planning • Safe Care of At-Risk Mental Health patient initiative

An additional 22 (17%) activities were identified as having addressed all aspects of the quality dimension recognized in SEAT (i.e., access, appropriate/effectiveness, efficiency, and safety). Examples included a specialist physician recruitment and retention initiative and development of an integrated palliative care approach,

It is important to note that not all FEI activities are successful (e.g., some activities in the SEAT database were delayed, did not have an outcome noted, or ended without sustaining changes or impact). The next phase of the evaluation will look beyond whether activities were noted as addressing a quality dimension and attempt to assess the level of impact the activities had on quality of patient care (this could also be added as an indicator in the SEAT database).

Preliminary Finding 2: There is some data to suggest that the FEI supports both indirect impacts to quality of patient care (e.g., increasing workplace satisfaction, relationship building amongst providers) as well as direct impacts (e.g., COVID-19 response planning, simulation training for physicians and other providers to enhance their competence and confidence in undertaking specific procedures).

A majority (59%, n=13) of key informants indicated that the FEI has contributed to improved quality of patient care to a great or very great extent, while slightly smaller proportions said the impact in this area was moderate (23%, n=5). Several key informants acknowledged that the ultimate goal of activities undertaken through the FEI are intended to improve quality of care provided to patients either directly or indirectly. In terms of indirect improvements, some key informants indicated that enhanced physician engagement in health system planning and decision making improves job satisfaction, which ultimately improves quality of care provided, which is aligned with the Triple Aim framework.[27] A few key informants also noted the benefits

[27] Ministry of Health plans for health system improvements are guided by the Institute for Healthcare Improvement's Triple Aim framework, which suggests that advancements need to improve health outcomes, patient and provider experience of care, and ensure efficient use of resources. Doctors of BC. 2017. Improving BC's Health System Performance. https://www.doctorsofbc.ca/sites/default/files/docsbc_health_system_performance_paper_v8b-web.pdf

of relationship-building activities funded through the FEI (e.g., informal social gatherings) which allowed providers to get to know one another and ultimately build better working relationships that had indirect benefits to the quality of patient care provided.

Several examples of direct patient care initiatives were also cited by key informants, such as efforts to maintain existing health care services in a rural area, simulation training for physicians and other providers to enhance their competence and confidence in undertaking specific procedures, and increasing physician awareness of modalities available for treating patients with chronic pain. The interdisciplinary simulation training to improve patient care is discussed further in the activity highlight box below.[28]

ACTIVITY HIGHLIGHT BOX: COASTAL SIMULATION PROGRAM

Location: Lions Gate Hospital (LGH), VCH | **Timing:** Fall 2018 (ongoing)

Description: Expansion of a site-based, foundation-funded simulation initiative by compensating physician participation, building capacity through training, and supporting development of a regional, physician-led, team-based simulation program

Objectives: To develop a sustainable program that 1) promotes team building, 2) encourages interdisciplinary learning, 3) improves patient care, and 4) fosters better relationships between departments

Funded: Sessional funding, training, video production, curriculum development

Outcomes:

Improved quality of patient care

Simulation training supports interdisciplinary teams to identify opportunities to optimize workflows and improve delivery of patient care. A survey of medical staff at LGH also found that simulations helped many physicians and allied health professionals gain confidence in procedures directly impacting patient care. For example, simulation participants learned how to use a LUCAS mechanical chest compression system, use of which has since improved resuscitation outcomes.

Strengthened relationships within and between MSAs

Team-based simulations build relationships and facilitate dialogue and collaboration within and across specialties and departments. Post-simulation debriefings in particular provide a common language and forum for various medical staff to engage in a different setting than usual, which can help to overcome existing tensions or barriers. By developing materials to engage with and support rural and remote sites in the region, the program is also strengthening relationships between MSAs.

Enhanced physician voice in planning and decision-making

Simulations generated evidence that supported physicians to engage the health authority to influence planning and decision-making. For example, physicians invited senior VCH leadership to observe a COVID-19 simulation in March 2020 to demonstrate the need for a system to manage COVID-positive patients to prevent widespread contamination throughout the facility.

"The simulation program is a great example of how you can take some funding from FEI and draw a direct line back to improved quality of care."

[28] Additional information about this activity can be located in the accompanied Collective Story Report.

Similarly, survey participants (n=113) through their qualitative responses indicated that the FEI and engagement activities more broadly have supported quality improvement projects and helped to foster an increased focus on improving quality and delivery of care. Examples included ER improvements, medical assistance in dying (MAiD) information and resources, maternity tours, and implementation of virtual health/home health services. In addition, survey participants (n=18) noted that the FEI and engagement activities have supported community connections and involvement. For instance, there was engagement between MSAs and First Nation patients and First Nations leadership as well as with community clinics and Family Physicians, and such connections can support quality and continuity of care. Participants (n=14) also noted that engagement has led to securing additional resources that positively impact the ability to deliver patient care – particularly by improving physician recruitment and securing another MRI machine (Fraser Health), as well as others (e.g., extra operating rooms - ORs).

Survey participants (n=140) through their qualitative responses also noted that the FEI and engagement activities supported rapidly developed and implemented COVID-related projects and measures to address patient and staff safety as well as access to and quality and continuity of care. Examples included planning and implementing assessment clinics, establishing hot and cold zones within facilities, providing PPE, and creating airway teams, and the launch of at-home care options (e.g., Hospital at Home).

Early Learnings to Support MSAs to Improve Quality of Patient Care:

Program Opportunity: Support MSAs to access guidance materials to help them assess the feasibility and effectiveness of their FEI activities and support increased completion of quality improvement initiatives (e.g., relevant Shared Care and Divisions of Family Practice guidance).

- A few key informants indicated that enhanced processes for assessing the feasibility and effectiveness of activities could support increased completion of quality improvement initiatives and scaling of successful activities across sites.

3.2 DESIGN, DELIVERY AND EFFICIENCY

The following sections outline the preliminary findings from the interim evaluation of the FEI in relation to key FEI design and delivery processes as well as the efficiency of program expenditures. In particular, key findings are presented in relation to:

- Stakeholder satisfaction with the investments made into key program elements
- The cost to implement the program

At the end of each section, a summary of early learnings is provided which identifies opportunities for the program, MSAs, HAs, and the evaluation to consider. It is important to note that "early learnings and opportunities" are not conclusive recommendations, as the findings are still in interim/preliminary stages.

Design and Delivery Processes: How satisfied are FEI stakeholders with the investments made into key program supports?

Stakeholder satisfaction with the investments made into key program elements was assessed through the key informant interviews. Key program supports were examined including the support provided by EPs, the FEI administrative systems (e.g., FEMS/FESC, SEAT, and SRRP), knowledge sharing products created by the provincial office, and the SSC FEWG. In addition, program supports to respond to the COVID-19 pandemic and HA roles, processes, and events that support physician engagement were also examined.

Preliminary Finding 1: Key informants were generally satisfied with the support provided by EPs and the more recently streamlined SRRP. However, there was a general lack of awareness of the provincial knowledge sharing products among these stakeholders (e.g., webinars, toolkits, reports, etc.) as well as the composition and role of the SSC FEWG in the FEI. Further, stakeholders were less satisfied with FEMS due to technological issues with the website being slow and prone to crashing as well as duplicative data being entered on SEAT. Stakeholders were least satisfied with SEAT and identified that there was low awareness and use of the platform.

The following table outlines the findings with regards to stakeholder satisfaction with key program supports, including the average satisfaction rating from stakeholders out of five (i.e., where 1 is unsatisfied, 2 is somewhat unsatisfied, 3 is neutral, 4 is somewhat satisfied, and 5 is satisfied) as well as the strengths and opportunities for improvement for each support. Indeed, several opportunities were identified to improve certain program supports which will be explored further in the next phase of the evaluation (e.g., feasibility of the opportunities).

Table 14: Key Informants' Satisfaction with FEI Program Supports

Program Supports	Average Satisfaction Rating	Strengths and Opportunities for Improvement
EPs	4.7/5	**Strengths:** • EPs were generally perceived to be integral to building relationships and facilitating communications and information sharing amongst key stakeholder groups, including between MSAs and HAs, amongst MSAs at different program facilities, and between MSAs and provincial FEI roles and structures • Key informants were pleased with the level of communication and support provided to MSAs to respond to COVID-19, particularly with respect to communicating guidelines for the allocation of FEI funds to COVID-19-related activities
		Opportunities: • A few key informants expressed concern that the level of support provided by the EPs to the MSAs would decrease going forward given the changing nature of the role to also provide support to the Divisions of Family Practice
FEMS and FESC	3.5/5	**Strengths** • Several key informants reported that they appreciated having the online FEMS system for processing claims (as opposed to a paper) and that the system was generally intuitive to use • The small proportion of interviewees that were familiar with FESC indicated that it was valuable for reducing the administrative burden of small program facilities, despite the initial learning curve to understand the system
		Opportunities • Some physicians and MSA project managers indicated that FEMS can be slow and prone to crashing and some concern was expressed by MSA project managers and EPs around the level of duplication between FEMS and SEAT, which increased the administrative burden to deliver the FEI • There may be an opportunity to better communicate to FESC facilities the overall purpose and function of FESC (e.g., how it functions compared to a traditional banking system)
SEAT	2.1/5	**Strengths** • Key informants were either unaware of SEAT or unsatisfied with the platform, no strengths were noted
		Opportunities • Several MSA project managers and EPs indicated that the overall purpose of SEAT could be clarified to better support its use. They perceived the purpose of SEAT to support information sharing across facilities but indicated that low usage amongst physicians and HA representatives limited its ability to serve this function • A few MSA project managers and EPs indicated that there was duplication between the information entered in SEAT and other administrative systems (e.g., FEMS and SRRP), which increased the administrative burden to deliver the program and added to the confusion regarding the role of SEAT in supporting program delivery. They suggested that efforts to combine administrative systems and streamline reporting requirements would improve administrative efficiency • Some FELs and MSA project managers also indicated that the overall functionality and value of SEAT was limited by the system's platform. For example, they noted that reporting functions were limited (e.g., it's not possible to filter information

Program Supports	Average Satisfaction Rating	Strengths and Opportunities for Improvement
		by facilities of similar sizes and funding amounts) and that it is difficult to delete activities once they are entered into the system
SRRP	4.2/5	**Strengths:** • Several EPs, MSA project managers, and physicians appreciated having a venue to bring together key stakeholders and collectively discuss work undertaken to date and next steps • There was acknowledgement and appreciation of the improvements made to streamline the SRRP process (e.g., elimination of in-person review meetings with SSC FEWG) and that the process has improved in the last two reporting cycles to reduce administrative burden
		Opportunities: • Key informants did not identify any opportunities for improvement however, the evaluation noted that the SRRP is a good source of information regarding the strengths and challenges encountered during FEI activities and provides a strong regional lens, which could be used more for the evaluation as well as a knowledge sharing tool
Knowledge Sharing Products	4.5/5	**Strengths:** • EPs and MSA project managers were generally familiar and satisfied with the knowledge sharing products (e.g., webinars, toolkits, reports, etc.), noting that the topics were timely and relevant (e.g., financial management and COVID-19), and that they appreciated being able to access these supports through the FEI website • A few of the physician and HA representatives expressed appreciation for tools and communications related to physician engagement and the finance-related webinars
		Opportunities: • Overall, physicians and HA key informants were generally unfamiliar with the knowledge sharing products (i.e., 11 reported being unfamiliar), suggesting an opportunity to disseminate knowledge sharing products more broadly
SSC FEWG	3.3/5	**Strengths** • A few key informants indicated that they received information from the WG through the EPs on a regular basis, such as updates regarding the COVID-19 funding guidelines for MSAs, which was valuable for keeping up to date on changes and decision-making occurring at the provincial level
		Opportunities • A majority of key informants were unfamiliar with the SSC FEWG and were therefore not able to comment to a great extent on the group's composition and governance, suggesting awareness could be higher of the role of the SSC FEWG in the FEI

Preliminary Finding 2: Key informants were satisfied with the support provided to respond to COVID-19 such as funding guidelines, sessional payments for physicians' time, and various communication strategies implemented (e.g., MSA monthly email newsletters and collaborative communications with HAs).

A majority of key informants were very satisfied with the program supports created and adapted to facilitate MSA response to the COVID-19 pandemic. Key informants provided several examples relating to administrative processes, funding mechanisms, and communications strategies. These FEI-funded activities were seen as integral to the MSA COVID-19 response.

- **Administrative Processes:** Several key informants reported that COVID-19 FEI funding guidelines developed by the provincial office were integral for communicating appropriate usage of FEI funds in a timely manner. Some EPs also noted the development of the COVID-19 Activity Tracker, which was helpful for supporting the program to document key activities undertaken in relation to the pandemic response.

- **Funding Mechanisms:** Several key informants were pleased with sessional payments provided for physicians' time to participate in the COVID-19 response planning, which was seen as integral to increasing physician engagement.

- **Communications Strategies:** Several communications strategies were also identified at both the local and provincial level, including FEI webinars delivered to support information sharing related to COVID-19, collaborative communications with the HAs in relation to pandemic planning, and MSA creation of weekly email newsletters to communicate key messages surrounding COVID-19 from various sources to MSA members.

The next phase of the evaluation will further examine COVID-19 related program supports and identify key strengths and/or challenges to share lessons learned from these activities.

Early Learnings Around Improvement Opportunities for Program Supports:

Program and MSA Opportunity: Increase awareness of the knowledge sharing products to FEI stakeholders as well as the SSC FEWG's role in FEI and how this governance structure can support MSAs in their work to engage with health system partners.

- Overall, physicians and HA key informants were generally unfamiliar with the knowledge sharing products (i.e., 11 reported being unfamiliar), suggesting an opportunity to disseminate knowledge sharing products more broadly.

Program and MSA Opportunity: Increase awareness about the SEAT platform and clarify the purpose of the database (i.e., information sharing platform). Also, look at options to improve the functionality of SEAT in terms of being able to sort and filter through information easily and in a way that is more useful to the user (e.g., filter by activities happening at the same facility size).

- Several MSA project managers and EPs indicated that the overall purpose of SEAT could be clarified to better support its use. They perceived the purpose of SEAT to support information sharing across facilities but indicated that low usage amongst physicians and HA representatives limited its ability to serve this function. Some FELs and MSA project managers also indicated that the overall functionality and value of SEAT was limited by the system's platform. For example, they noted that reporting functions were limited (e.g., it is not possible to filter information by facilities of similar sizes and funding amounts) and that it is difficult to delete activities once they are entered into the system.

Evaluation Opportunity: Consider alternative methods to collect information regarding HA roles, processes, and events designed to improve engagement with physicians for the next phase of the evaluation.

- There was a lack of information about HA roles, processes, and events developed by HAs to improve physician engagement with the HAs and requires further analysis during the next phase of the evaluation.

Efficiency of the FEI: What was the cost to implement the program?

The costs to implement the FEI were examined by looking at facility expenditures by HA and tier (i.e., amount spent and key expenses), including an examination of COVID-19 related expenditures. In addition, a take-up analysis of the program was undertaken to determine if differences existed between different regions or tiers with regards to accessing the program. Finally, the costs to operate the program were also explored, including expenditures by the provincial office (e.g., staff salaries, employee benefits, training and development, and outside help). The next phase of the evaluation will further examine the costs of the FEI, including a comparison between 2019-20 and 2020-21 expenditures.

Preliminary Finding 1: The cost to implement the FEI was just over 19M in 2019-20. Most program costs related to facility-level expenditures on engagement activities, including sessional costs, internal operating expenses, and office and communication expenses to support MSA operations.

As identified previously, the cost for the FEI was just over $19M in 2019-20. The majority of program costs related to facility-level expenditures on engagement activities, including sessional costs, internal operating expenses, and office and communication expenses to support MSA operations. Table 15 below outlines program resources for 2019-20.[29]

Table 15: FEI Expenditures, 2019-20

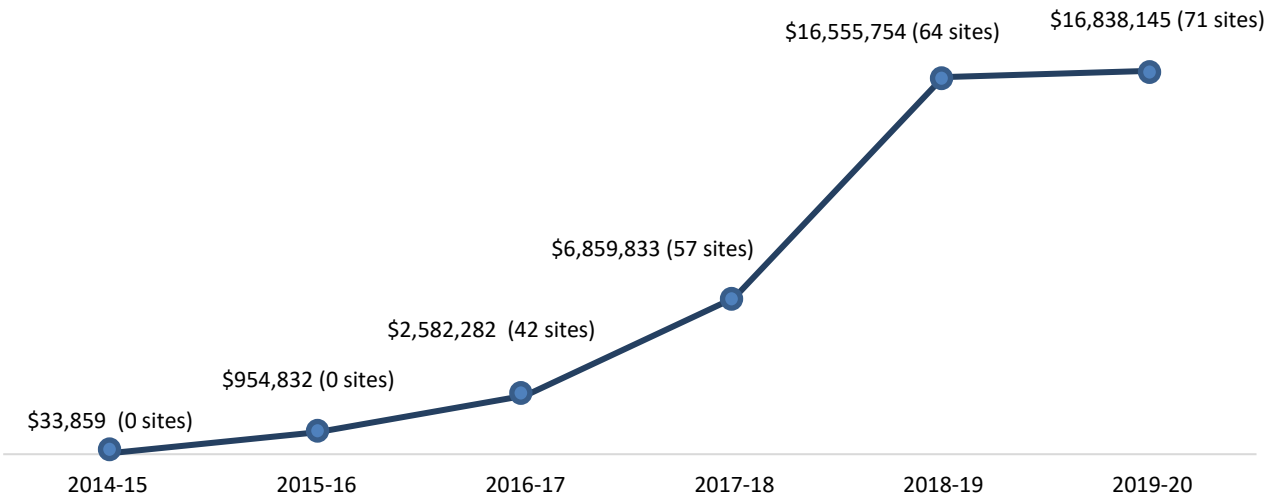
Expenditures	2019-20
Facility Expenditures	$16,838,145
Operating Expenditures	$2,532,188
Total	**$19,370,333**

[29] Financial information was only illustrated for 2019-20 given the scope of the evaluation and significant financial policy changes implemented in 2018-19 that make it difficult to compare costs from previous years.

Total Facility Expenditures by Fiscal Year

Since program implementation in 2014-15, there has been a steady increase in the number of participating facilities and total facility expenditures (figure 16). By 2019-20, 71 facilities had participated in the FEI and facility expenditures were $16,838,145 (the largest expenditure amount to date).

Figure 15: Program Expenditures, 2014-15 to 2019-20



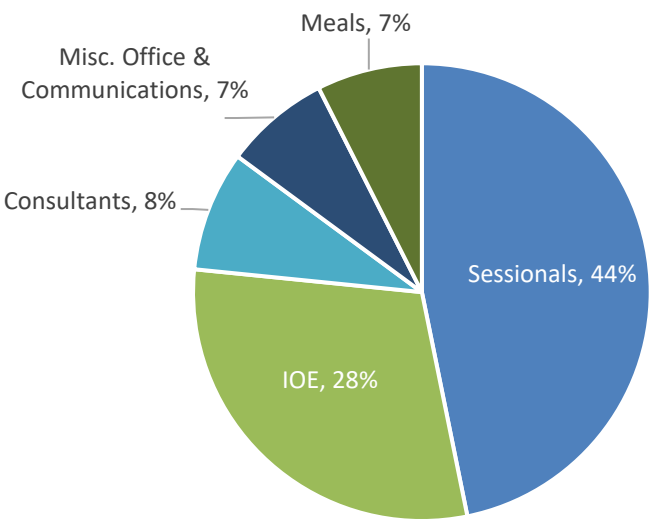
Facility expenditures have generally trended upwards across HAs since the FEI launched in 2014-15. However, expenditures in some HAs decreased after 2018-19 (i.e., PHSA and IHA). In 2019-20, the largest proportion of expenditures were attributed to FHA (24%), followed by IHA (22%), VCH (20%), VIHA (18%), PHSA (8%), and NHA (8%). In terms of facility size, Tier 5 and 6 facilities accounted for the largest expenditure amounts in 2018-19 and 2019-20, followed by Tiers 2, 3 and 4, and 1. Expenditures in the smallest (Tier 1.1) and largest (Tier 6) facilities decreased in 2019-20 compared to the previous year but increased notably for Tier 1.2, 4, and 5 facilities. Expenditures at Tier 1.3 and 3 facilities were relatively stable year over year.

Top Five Facility Expenditures in 2019-20

As illustrated in the figure below, the top five expenditures for all facilities in 2019-20 were sessionals, internal operating expenses (including MSA project manager and administrator costs), miscellaneous office and communication expenses, consultants, and meals.[30] Spending patterns were relatively consistent across HAs, with some exceptions. Example, VIHA reported significantly higher (53%) expenditures on sessionals compared to the provincial average (44%)., Whereas, PHSA reported significantly lower (25%) because majority of physicians in PHSA are alternately-paid positions (rather than fee-for-service) and therefore make fewer sessional claims. Unlike other HAs, alternately-paid physicians generally limit sessional claims to events that take place after regular office hours.

[30] Internal operating expenses (IOE) are site expenses that are necessary for running a MSA and functioning of the FEI. This primarily includes MSA project manager and administrative support costs but also, accountant invoices, office rent, office supplies, utilities, insurance, banking fees, and other expenses that support the MSA infrastructure.

Figure 16: Top Five Facility Expenditures, 2019-20



COVID-19 Related Facility Expenditures

The FEI confirmed that program funds could be used for physicians' time spent in COVID-19 activities with colleagues and HA; in accordance with the FEI funding guidelines in May 2020. Additionally, qualifying facilities were provided their next gate of funding in March 2020, of approximately $2.5 million (along with tools to assist MSAs with financials). As of May 21, 2020, 69 facilities had used FEI funding for COVID-19 activities at local and regional levels.[31]

According to data retrieved from FEMS, the total value of facility expenditures related to COVID-19 in the 2019-20 fiscal year is estimated to be $856,853.[32] Most COVID-19-related costs (95%) were related to time (i.e., amount claimed for sessional time), while a small proportion (5%) represented other expenses. More than half (56%) of claims submitted for FEI activities related to COVID-19 were from Tier 5 and 6 facilities, followed by Tiers and 2 (25%), and Tiers 3 and 4 (19%).

Preliminary Finding 2: Program take-up across all facilities in 2019-20 was 81% when comparing the annual funding amount to the transfer amount and this differed depending on the HA and size of the facility. However, the large carry-over amount made it challenging to understand program take-up for 2019-20, as facilities were accessing additional funds beyond the transfer amount (i.e., overall facilities expended 112% of their annual funding amount in 2019-20). Early results suggest that new policies around gated funding and no carryover have led to facilities no longer accumulating excess funds.

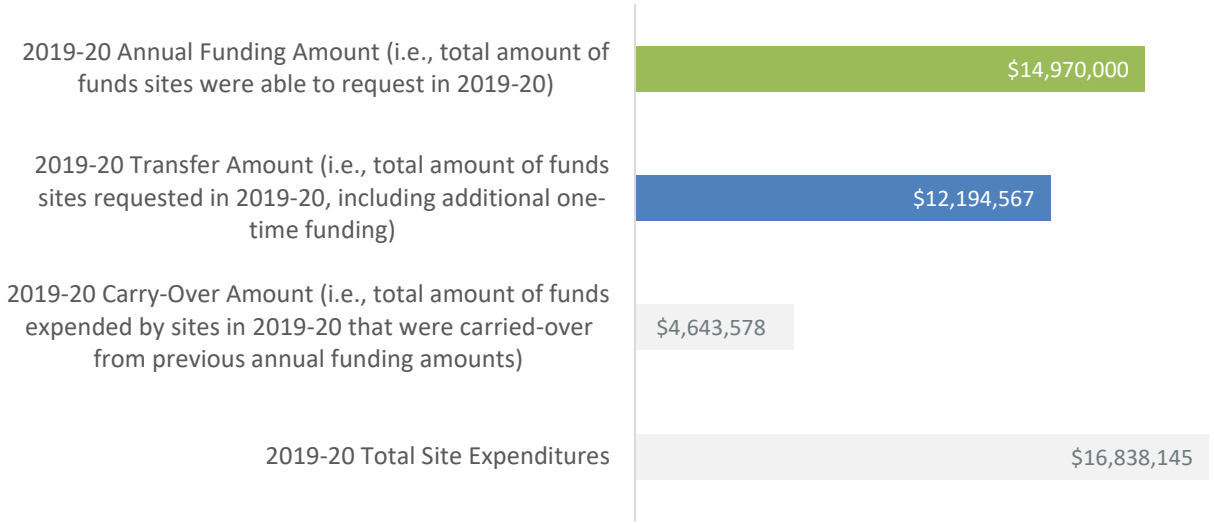
As illustrated in Figure18 below, program take-up across all facilities in 2019-20 was 81% when comparing the annual funding amount to the transfer amount. Annual funding amounts for facilities that participate in the

[31] Doctors of BC. 2020. Key Highlights: SSC Facility Engagement Working Group (SSC FEWG): May 19, 2020. http://www.facilityengagement.ca/sites/default/files/SSC%20FE%20WG%20Meeting%20Summary%20May20%202020Mtg__F.pdf

[32] Based on 2,386 claims. Actual number and dollar value of COVID-19-related activity claims is likely higher, as not all activities were able to be retrieved from FEMS (e.g., did not have "COVID-19" in activity title or description).

FEI is based on the number of acute care beds and generally ranges from $35,000 (Tier 1.1 facility) to $500,000 (Tier 6 facilities). Across HAs, take-up of annual funding amounts was highest at FHA (98%), VCH (94%), followed by PHSA (84%) and IHA (82%), and finally, VIHA (75%), and NHA (28%). Further, take-up of annual funding amounts were highest at the largest facilities, which were transferred up to 120% of their annual funding amounts. Conversely, the smallest facilities had the lowest take-up rates, ranging from 7% to 44% across Tier 1 and 2 facilities. Facilities that were transferred more then their entitled annual funding amount received one-time site contingency funding for activities that required additional funds (e.g., one facility needed additional funding transferred after engaging with a large regional project which cost more then their annual funding amount).

Figure 17: Program Take-Up by Annual Funding Amount and Transfer Amount, 2019-20



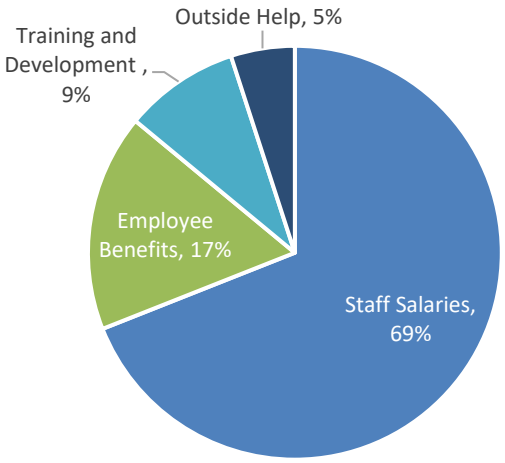
As illustrated in the figure above, facilities also had access to carry-over amounts from previous fiscal years. More specifically, up to and including 2018-19, facilities were transferred their full annual funding amounts at the beginning of the fiscal year (i.e., ranging from $35,000 for Tier 1.1 facility to $500,000 for Tier 6 facilities) and unspent amounts remaining at the end of the fiscal year could be carried over to future years. For example, in 2019-20, facilities expended 112% of their allocated annual funding amount due to having access to carry-over amounts.

As a result of concerns arising from significant unspent funds each fiscal year, in 2019-20 the FEI implemented a gated funding policy and a no carryover policy. With the exception of Tier 1 facilities, funding is now 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. Early results suggest that new policies around gated funding and no carryover have led to facilities no longer accumulating excess funds. This will be further explored in the next phase of the evaluation.

Preliminary Finding 3: A smaller proportion of expenses supported the provincial office to operate the FEI, such as staff salaries and benefits.

The cost to operate the FEI in 2019-20 was $2,532,188 or 13% of the total program budget when accounting for staff salaries[33], employee benefits, training and development, and outside help for the provincial office. This was consistent with 2018-19 operation costs of $2,553,882. The specific breakdown of the costs to operate the program are illustrated in the figure below.

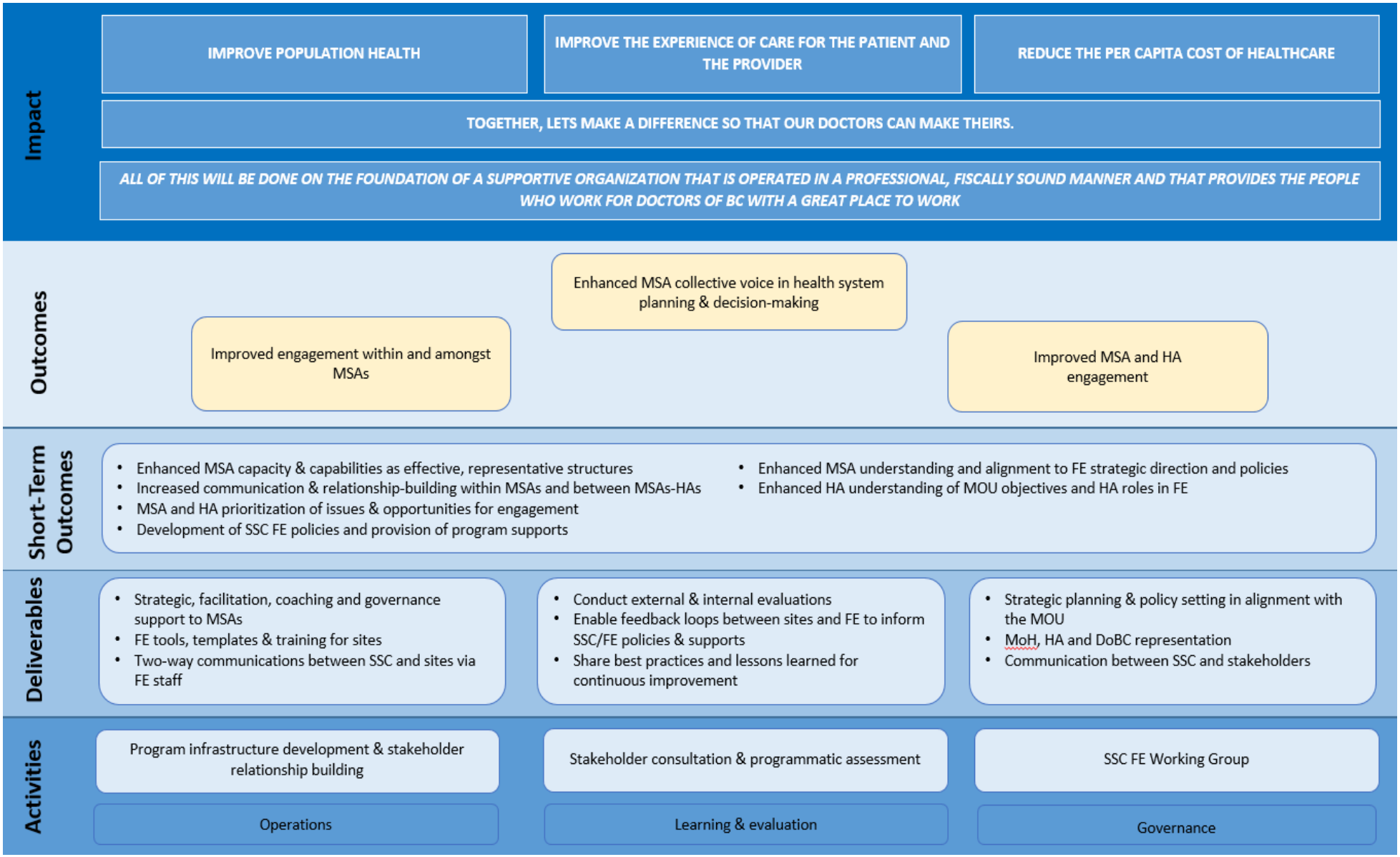
Figure 18: Operating Expenditures, 2019-20



[33] Staff salaries include 17-20 EPs, all of whom work remotely in and around the facilities that they support. There are also nine staff that support FEI initiatives in relation to overall policy, financial, and technology support.

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
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
		Doctors of BC survey	• # and % of participants with increased positive scores to “this organization values physician contributions” • # and % of participants with increased positive scores to “I feel meaningfully engaged in my organization” • # and % of participants with increased positive scores to “Senior leaders’ decision-making is transparent to physicians” • Questions related to COVID-19
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)
FE Process	**Evaluation Question**	**Data Sources**	**Indicators**
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