Evaluation of the Facility Engagement Initiative 2.0

COLLECTIVE STORY REPORT

EXECUTIVE SUMMARY

Report Overview

The Facility Engagement Initiative (FEI) 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. It is a province-wide initiative aimed at strengthening communication, relationships, and collaboration between facility-based physicians and health authorities across BC. Expected outcomes include:

1. Improved engagement within and amongst Medical Staff Associations (MSAs)
2. Improved MSA and health authority engagement
3. Enhanced MSA collective voice in health system planning and decision-making

As part of an Evaluation of the FEI, an initial set of qualitative story interviews were conducted between September and November 2020 with 14 stakeholders such as physicians, health authority representatives, MSA project staff, and others to collect rich information on five activities funded through FEI (shown below).

Featured Activities (by Region)

Fraser	2020 COVID Response: Virtual Health
Interior	East Kootenay Patient Transportation Committee
Vancouver Coastal	Coastal Simulation Program
Vancouver Island	Better Use of VIHA Secure Email

This report summarizes findings about the featured activities (i.e., 'stories') and their progress toward expected outcomes, as well as overarching findings from an interim analysis across stories. Each story is based on 3-4 telephone interviews and available documents/data such as project funding applications.

Progress Toward Outcomes

Stakeholders of two or more featured activities identified shared progress and achievements related to the expected outcomes of the FEI in the following areas:

- **Improving engagement:** Most featured activities helped to strengthen relationships and/or communication within and among MSAs or between MSA members and other health system partners by providing a platform or opportunity around which stakeholders could establish connections, identify shared interests, and work together. Engaging key personnel in a meaningful manner most positively impacted relationships as well as the success of funded initiatives. For instance, initiatives that involved early and ongoing collaboration and partnership between MSA members and health authority staff were characterized as having more buy-in and success than initiatives whose leads only consulted or informed other affected stakeholders. Activities in the latter category were more likely to have overlooked opportunities for input from, or collaboration with, key decision-makers.

- **Enhancing MSA collective voice:** Some featured activities strengthened and amplified MSA collective voice by providing opportunities for meaningful and deliberate physician/MSA consultation and collaboration about facility- or regional-level issues that affect physicians' work environment and

patient care. For example, the East Kootenay Patient Transportation Committee gave physicians from multiple sites a seat at the table for planning and decision-making around patient transportation issues.

In addition, all featured activities aimed to improve patient care or enhance physicians' ability to deliver care. While it is too soon to assess outcomes for many featured activities, two have been credited with improvements to care. In the Fraser Health region, for example, virtual health technologies were implemented to reduce unnecessary in-person patient-provider contact to mitigate against exposure to COVID-19 while maintaining access to quality care and allowing patients to stay connected with friends and family while isolated in the hospital.

Key Lessons

Together, the qualitative stories underscore common enablers, barriers, and opportunities to support and enhance facility engagement further. Key lessons include:

1. **Developing relationships and a foundation of collaboration** creates opportunities for continued engagement and supports identification of, and response to, challenges such as emerging health threats (e.g., COVID-19) and differences in understanding or expectations among stakeholders.

2. **Identifying and engaging affected stakeholders with appropriate knowledge and decision-making authority** early in the development of a new initiative is key to generating buy-in and support as well as leveraging partnership opportunities. Failure to do so can strain relationships and limit success.

3. **Providing support, particularly sessional funding as well as administrative support**, encourages and enables physicians to collaborate with each other, other medical staff, and health authority staff, as well as to participate in engagement initiatives – for instance, team-based simulation training and multi-stakeholder committees. Such activities can help to establish and amplify physicians' collective voice.

4. **Demonstrating openness and responsiveness to issues that are important to physicians** can strengthen relationships between physicians and health authority staff and positively impact physician engagement.

5. **Securing adequate resources from health system partners** may be necessary for individual engagement initiatives to succeed – for example, funding to purchase, or personnel to implement, new technology or to address challenges or opportunities identified through collaborative processes and structures.

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ACRONYMS AND ABBREVIATIONS

ACP	Advanced Care Planning
BC	British Columbia
BCEHS	BC Emergency Health Services
EP	Engagement Partner (formerly known as Facility Engagement Liaison)
FEI	Facility Engagement Initiative
FHA	Fraser Health Authority
HA	Health Authority
IAP2	International Association for Public Participation
IHA	Interior Health Authority
IMIT	Information Management/Information Technology
IT	Information Technology
LGH	Lions Gate Hospital
MSA	Medical Staff Association
PTN	Patient Transfer Network
SEAT	Site Engagement Activity Tracker
SSC	Specialist Services Committee
QI	Quality Improvement
VCH	Vancouver Coastal Health Authority
VIHA	Vancouver Island Health Authority

1. INTRODUCTION

Facility Engagement Initiative

Objectives

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 health authorities (HAs) across BC. The goal is to improve physicians' work environment and ultimately the delivery of patient care by achieving the following expected outcomes:

1. Improved engagement within and amongst Medical Staff Associations (MSAs)
2. Improved MSA and HA engagement
3. Enhanced MSA collective voice in health system planning and decision-making

Activities

FEI activities are led and coordinated by MSAs or Physician Society working groups at eligible sites (i.e., health care facilities with acute care beds) throughout the province. Funding is available for activities that provide opportunities and support for physicians and HA leaders to work together, for MSAs to develop a meaningful voice and increase involvement in local activities that affect their work and patient care, and for physicians to get involved in decision-making. Eligible activities include MSA Governance/Administration costs, sessional costs, consultation fees, quality improvement (QI) initiatives, cross-departmental initiatives, and more.

Resources

The cost to run the FEI is just over $19M per year, with annual funding for participating sites varying from $35,000 (for sites with 0 to 7 acute care beds) to $500,000 (for sites with >301 acute care beds).

Collective Story Report

Objectives

An Evaluation of the FEI is being undertaken to support learning and accountability. As part of this evaluation, an initial set of qualitative story interviews were conducted with physicians, HA representatives, MSA project staff, and FEI staff to collect rich data on FEI outcomes and develop narratives highlighting the impact of MSA activities and processes. Interviews were not intended to assess the value or performance of the featured activities or participating stakeholders.

Methodology

A total of 14 interviews were conducted between September-November 2020 to develop four stories about featured activities and inform interim evaluation findings. Featured activities were purposefully selected to explore and illustrate key challenges and successes of the FEI identified through other lines of evidence. Each

story is based on 3-4 telephone interviews with stakeholders involved in a given activity as well as available documents and/or data (e.g., project funding applications, Site Engagement Activity Tracker (SEAT) data, and activity outputs). Data were thematically analyzed by story and across stories to group and identify emergent themes related to the expected outcomes of the FEI. This report presents key themes by story and overall.

Structure of the Report

Section 2 of the report summarizes each story and the featured activity's achievement of, or progress toward, expected outcomes of the FEI. Factors contributing to challenges and success are also explored. Section 3 follows with a description of overarching findings from an analysis across stories.

Additional information about the methodology (including strengths and limitations) is provided in the Appendix.

2. STORY SUMMARIES

The following pages provide a detailed summary of each qualitative story. **Purple text is used to highlight key details** for individuals interested in quickly developing a high-level understanding of activity context, processes, and outcomes, as well as lessons learned from each. These details are situated alongside additional detail, examples, and quotes for those interested in learning more.

Two frameworks are used to describe the **type(s) of work** and **type(s) of engagement** involved in each activity:

Types of Institutional Work	The model for institutional work developed by Cloutier et al.[1] was used to describe the type(s) of work involved in each activity to support or enhance facility engagement. The four types of institutional work are: 1. **Relational work:** efforts to build connections, trust and collaboration within the medical profession and with health system managers 2. **Conceptual work:** efforts to establish and communicate ideas and beliefs consistent with intended changes 3. **Structural work:** efforts to establish formalized roles, rules and policies that support intended changes 4. **Operational work:** efforts to implement concrete initiatives and actions that advance or cement in place desired changes

Types of Engagement	The FEI adapted the International Association for Public Participation's (IAP2) framework for public engagement[2] to articulate how medical staff and HAs engage with one another. These categorizations (shown in the figure below) are used to describe the type(s) of engagement that occurred in each activity:

	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.

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[1] Cloutier, Charlotte, et al. "Agency at the managerial interface: Public sector reform as institutional work." *Journal of Public Administration Research and Theory* 26.2 (2016): 259-276.

[2] 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

Implementing Virtual Health to Improve In-Patient Care During COVID-19

What was the challenge or opportunity?

COVID-19 necessitated that providers, HA administrators, and patients rapidly adopt new infection prevention and control measures, including visitor bans. Key challenges in an in-patient setting included the need to **limit patient-provider interactions** to mitigate the risk of viral transmission as well as to **preserve the limited PPE supply**, all while maintaining a high quality of patient care. Further, **patients faced loneliness and isolation** due to lack of visits from, and connections to, family and friends and inability to leave their room.

Physicians also worried that many patients had not engaged in prior Advanced Care Planning (ACP) discussions, which could become a pressing issue. **Facilitating ACP can take an emotional toll** on physicians, contributing to **burnout/disengagement**.

> ### ACTIVITY PROFILE
>
> **2020 COVID Response: Virtual Health**
>
> **Location:** Royal Columbian Hospital, Fraser Health Authority (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 ACP, reduce contact between patients and staff, and increase communication between patients and family members
>
> **Type of Institutional Work:** Conceptual
>
> **Objectives:** To 1) 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

How was it addressed?

Seeing the potential for virtual technology to address COVID-related challenges in an in-patient setting, four **physicians at RCH collaborated to apply for rapid access FEI funding** for a physician-led project to:

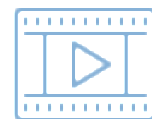1. **Acquire and implement virtual technology and educate medial staff on its use**

   Zoom and Facetime for video communication/consultation

   Bluetooth-enabled technology for remotely monitoring patient vitals

2. **Develop educational materials for patients**

   E.g., a standardized message and educational video to support discussions with patients about ACP

Supported by FEI funding and a nurse educator, the Physician Lead **engaged with HA administrators and the hospital foundation** through meetings to develop relationships and discuss key aspects of the initiative, including feasibility and policies/procedures for integrating new technology. As a result, the initiative secured HA buy-in and hospital foundation funding for the purchase of technology (iPads) for in-patient wards. The Physician Lead also connected with the Health information technology (IT) and patient education offices about processes for developing patient education materials and to request support connecting with vendors about device and data options.

Project participants met regularly to move the project forward. This involved considerable **collaboration and problem solving with the HA** to address technical and logistical challenges as patients began to use the iPads.

CHALLENGES	Limited wifi/data access	Storage and security issues	Damage during cleaning
Patient privacy and confidentiality concerns	Limited patient/provider technological skills	Software incompatibility with existing platforms	Corporate use restrictions (e.g., no games)

While medical staff broadly supported implementation, there was nonetheless **some resistance to learning** how to use new technology. Development and integration of patient education materials is ongoing.

What are the outcomes?

Improved delivery of safe and supportive patient care	**Strengthened relationships between medical staff and the HA**	**Supported health system optimization and innovation**
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 isolation by enabling patients to safely connect with friends and family, improving wellbeing.	Engaging HA staff to get project approval and support allowed medical staff to learn about key players and processes in the HA and engage meaningfully in planning and decision-making conversations.	Engagement supported novel and rapid implementation of virtual technologies in an in-patient setting, resulting in reduced PPE usage and prompting innovative thinking among medical staff. For example, medical staff quickly identified 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 HA 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."

Key Lessons

1. **Developing relationships and a foundation of collaboration creates opportunities** for continued engagement. FEI provides a platform through which different stakeholders can engage, build relationships, and identify shared interests.
2. **Providing support and addressing issues of importance to physicians** strengthens relationships between physicians and the HA and positively impacts physician engagement.
3. **Sessional funding encourages and enables physicians to collaborate** with each other, other medical staff, and HA staff.
4. **Resistance to change can limit or delay uptake** of new processes and require time and persistence to address. For this activity, one participant noted that going forward they will focus on determining how to increase medical staff buy-in for in-patient use of virtual health technologies.

"Being supported goes a long way. That makes everything better for the working environment, patient care, and health care system."

Sources: *Project Grant Application, Telephone Interviews (4) with: 1 Physician Lead, 2 Physician Working Group members, 1 HA representative (Nurse Educator)*

Addressing Rural Patient Transport Challenges Through Regional, Multi-Stakeholder Collaboration

What was the challenge or opportunity?

FEI Project Managers and Engagement Partners (EPs) at different facilities in the East Kootenays realized through regular communication and collaboration with physicians and HA staff that **the same challenges were being raised when patients required transport** to a regional or tertiary centre to receive a higher level of care. Specifically, while there is a High Acuity Response Team based in Cranbrook that can dispatch a "mobile intensive care unit" to communities in the region, BC Emergency Health Services (BCEHS) does not have an air ambulance stationed in the region and there are no on-the-ground critical care paramedics in the region's many rural and remote communities. There is also a **lack of awareness about the Patient Transfer Network**'s (PTN) role in coordinating patient transfers province-wide among some physicians, as well as **limited knowledge of political factors** that constrain the PTN's ability to facilitate certain transfers, particularly to facilities in Alberta.

ACTIVITY PROFILE
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 MSA physicians, HA representatives, and BCEHS together to collectively examine and address challenges with patient transport in a rural setting
Type of Institutional Work: Conceptual
Objectives: To 1) improve the patient transport experience for local physicians and 2) build relationships between smaller facilities and the regional centre
Funded: Sessional funding, food, physician travel, project management support

As a result of the complex system, some **patients were waiting to receive critical care** and there was **tension between health system partners** due to frustration and misunderstanding around processes. Physicians, Interior Health Authority (IHA), BCEHS, and other regional stakeholders all **shared interest in improving patient transportation** in the region.

How was it addressed?

Based on a recommendation from a 2018 Kimberley Regional Meeting that was positively received by stakeholders, an **East Kootenay Working Group was formed**. Its purpose was **to explore using FEI funds** for a pilot project aimed at improving the patient transport experience for local physicians and building relationships between IHA and MSAs at the regional centre in Cranbrook and smaller surrounding facilities.

A Committee meeting

Supported by FEI funding and project management support, 15 individuals representing all five MSAs in the East Kootenays, IHA administrators and project leads, BCEHS, and a provincial Working Group **formed the East Kootenay Patient Transportation Committee** in Fall 2018. The committee **began work by developing Terms of Reference and conducting a scan of current work** around patient transportation at the local, regional, and provincial levels. Both regional MSA members and IHA administrators were invited to provide input. An **EP and FEI Project Managers provide ongoing administrative support**, such as preparing meeting agendas, organizing events and meetings, and taking minutes.

Next, the **committee developed strategic priorities** to guide its work (summarized in the table below). While the committee's work is ongoing, meetings were largely paused in 2020 due to COVID-19.

Strategic Priorities	Work Undertaken
1. Develop and share knowledge on issues impacting patient transport	Quarterly meetings including guest speakers (24 total participants across 8 meetings since Fall 2018)
2. Measure and assess the current state of patient transport	Cranbrook collected, analyzed, and presented data on patient transport (e.g., destinations, wait times)
3. Build and support capacity of interdisciplinary teams at rural facilities	IHA representative organized simulation education and training on patient transportation for rural facilities
4. Cultivate a collective, multi-stakeholder regional voice to influence policy	Committee has voiced concerns as a group, supported by documentation, data, key stakeholders

What are the outcomes?

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 BCEHS to discuss PTN decision-making processes and address questions and concerns.

Increased physician engagement and capacity

Providing a forum and support in the way of funding has been motivating for physician 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 at regional and provincial conferences.

"It's helped us to liaise better with stakeholders and service providers with a collective voice."

Key Lessons

1. **Sessional funding and project management support** encourages and enables physicians to participate in engagement activities such as multi-stakeholder committees.
2. **Identifying and including appropriate partners** from affected stakeholder groups and establishing common interest is a prerequisite for successful engagement and collaboration.
3. **Demonstrating openness to addressing issues of importance to physicians** motivates physicians to engage with HAs.
4. **Adequate resources and/or political will need to accompany engagement efforts** to address health system challenges. For this activity, one key informant noted seeing more improvement to patient transportation following an influx of resources in response to COVID-19 than through the Committee's prior efforts.

"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."

Sources: Interior Health Showcase Presentation (September 2020), Telephone Interviews (4) with: 1 Physician Committee member, 1 MSA Project Manager, 1 HA representative, 1 external stakeholder (BCEHS)

Expanding Inter-Disciplinary Simulation Training to Improve Patient Care

What was the challenge or opportunity?

Seven years ago, the Lions Gate Hospital (LGH) Foundation provided funding to develop a simulation program after engaging physicians and being surprised to learn there was **no team-based training** for any of the hospital's care teams or hospital-wide responses (e.g., Code Blue). With the Foundation's support, LGH hired an external consultant and conducted research and engagement on simulation training. These efforts culminated in **establishing space** in The Greta and Robert H.N. HO Psychiatry & Education Centre (the HOpe Centre) **to operate a new simulation program** and **funding nurse educators and equipment** such as simulated patient monitors.

Despite broad support for the new program, **physicians were not rushing to participate without access to funding** support for their time – something that fell beyond the Foundation's mandate and that Vancouver Coastal Health (VCH) could not provide.

ACTIVITY PROFILE
Coastal Simulation Program
Location: LGH, VCH
Timing: Fall 2018 (ongoing)
Description: Expansion of a facility-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
Type of Institutional Work: Structural
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

How was it addressed?

When the FEI was established in 2015, LGH established a **Steering Committee with HA and physician representatives** plus an **MSA Executive** to determine which projects to support through FEI. Together, these groups **engaged in dialogue to identify alignment** between MSA and HA interests, ultimately finding strong shared support for increasing physician participation in the Foundation-funded simulation program.

> *"The FEI timing was impeccable. At this point I just couldn't get docs to come to the sims training but we had everything else in place."*

They **applied for, and received, FEI funding** in Fall 2018 to expand the Coastal Simulation Program through:

1. **Support for increasing the number of simulations** at LGH

2. **A "train-the-trainer" course** to build capacity for physician leaders to facilitate simulations that include post-simulation, team-based briefings

3. **Sessional funding** for physicians' participation in LGH simulations

4. **Developing curriculum and materials for a regional simulation program** to support facilities in other coastal communities to implement simulation training

OUTPUTS March-May 2020	2,140 Learners	674 Simulation Scenarios	79 COVID-19 Simulations	13 Train-the-Trainer Workshops	31 Workshop Participants from 6 sites	3 Instructional Videos Created

The LGH simulation program now runs weekly emergency team simulations, bi-weekly pediatric and ICU simulations, and other simulation initiatives as required. For example, the emergency department conducted two months of weekly simulations in conjunction with the neurology department following the release of a provincial mandate to improve the timeliness of care received by patients presenting with possible stroke.

LGH Simulation Program

What are the 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.	*"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."*
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 facilities 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 HA 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.	

Key Lessons

1. **Developing relationships and a foundation of collaboration** supports health system responsiveness to emerging challenges (e.g., COVID-19) and opportunities (e.g., FEI funding).
2. **Providing a safe, supportive platform for engagement** around a common interest strengthens relationships among medical staff and between medical staff and HA leadership.
3. **Sessional funding encourages and enables physicians to participate** in engagement activities such as team-based simulation training.
4. **Having sufficient resources supports engagement initiatives to be successful** – for example, nurse educators and equipment that were funded by the LGH Foundation in this activity.

Sources: SEAT data, VCH Simulation 2019-20 and Coastal Simulation Program 2019-20 Infographics (September 2020), Telephone Interviews (3) with: 1 Physician Lead, 1 Physician participant, 1 HA representative

Addressing IT Barriers to Improve Communication, Relationships, and Patient Care

What was the challenge or opportunity?

Physicians working within Vancouver Island Health Authority (VIHA) have had a longstanding desire to move beyond notes, hallway conversations, telephone, and fax to increase inter-clinician communication and improve patient care. **Physicians generally do not use their secure email addresses provided by the HA** because of the high volume of **irrelevant emails and spam** (e.g., building and IT notifications) and **technological limitations** such as being unable to remotely access email from a mobile device.

As a result, other clinical and HA staff often have difficulty reaching physicians, which can lead to **disjointed communication, delays in patient care, and lost opportunities for engagement**. For instance, HA staff may have limited ability to share information about meetings or initiatives in which physicians can get involved (e.g., QI projects).

How was it addressed?

A physician leader devised an IT solution to address VIHA email limitations and **connected with other physicians and HA staff to gauge interest and feasibility** of the proposed approach. This included trialling an email filter with 10 physicians as well as **consulting the VIHA privacy and communications departments** about the implications of creating an email database and filtering out certain HA communications such as building notifications. The **MSA supported HA consultation**.

Upon receiving **buy-in** from VIHA Information Management/ Information Technology (IMIT) staff and **encouragement** from the South Island MSA Project Manager, the Physician Lead **applied for FEI funding** to continue the work. This supported subsequent **collaboration with a Senior Technical Analyst, Director, and IT Operations to implement the email filter**, after which any physician with a HA email could access an IT web page to engage the filter and adjust other email settings. The Project Lead is now **raising awareness of the filter through networking and word-of-mouth** and plans to utilize strategic communications (e.g., attending department meetings) to reach all eligible physicians. The **remainder of the IT solutions will be developed and implemented in coordination with IMIT** as resourcing permits.

Despite the Physician Lead's engagement with HA staff prior to submitting an FEI funding application, **other VIHA staff began**

ACTIVITY PROFILE

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

Type of Institutional Work: Relational, conceptual

Objectives: To 1) 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, project management support

Physician-led IT Solution

- Filter unsolicited emails out of physicians' inboxes
- Enable 'out-of-office' messaging to clarify which physicians do not use VIHA email
- Streamline processes, such as for Medical Office Assistants to monitor email
- Educate on email access options (e.g., from a physician's private office)

making some similar changes to HA communications processes **around the same time** in response to information demands resulting from the COVID-19 pandemic. These changes included consolidating messaging into a twice-weekly newsletter and developing an email filter that medical staff could use for their preferred email (i.e., VIHA email or other). The **parallel initiatives** were both already underway when the VIHA staff who were involved were informed of the physician-led project, while the Physician Lead was only minimally aware of the extent to which the HA staff shared similar interests. This not only led to **overlooked opportunities to collaborate and leverage each other's insight and resources**, but also contributed to **some confusion among medical staff who were receiving conflicting messages** about which email and processes they should use.

> *"The biggest challenge with these physician-led projects… Sometimes, if we're not having the right consultations and conversations, we can go down separate paths when we really want to maximize the collective wisdom and power of people in different areas of the same work."*

What are the outcomes?

Supported engagement among physicians	**Increased communication between physicians and HA staff**
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.	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 the HA staff involved. 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 [VIHA] 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."*

Planned measurement of email usage pre- versus post-implementation and satisfaction with VIHA secure email will better indicate whether the activity is increasing physician use of HA email, which could in turn enhance communication and collaboration among physicians and between physicians and HA staff.

Key Lessons

1. **Utilizing project management strategies** such as conducting an environmental scan or needs assessments can help to identify affected stakeholders, available resources, and related work prior to ensure relevance, feasibility, and buy-in for new initiatives.
2. **Identifying and engaging stakeholders with appropriate knowledge and decision-making authority** early in the development of a new initiative is key to leveraging partnership opportunities as well as the insight and resources or other stakeholders.
3. **Conducting outreach and providing physicians with sessional funding as well as information** can increase physician interest and participation in engagement activities. MSAs can be a conduit for information-sharing.

Sources: Project grant application, Telephone Interviews (3) with: 1 Physician Lead, 1 MSA Project Manager, 1 HA representative

3. OVERALL FINDINGS

Key themes in relation to achievement of expected outcomes of the FEI that emerged from analysis across the qualitative stories are summarized below.

Engagement Within and Amongst MSA

Activity implementation helped to establish and strengthen relationships **by providing a platform or opportunity around which physicians could engage with each other**. For instance, this included a regional, multi-stakeholder committee in IHA and engagement with other physicians to first gauge interest/feasibility and then raise awareness of the email filter in VIHA. **Key enablers** that allowed physicians to participate in engagement activities included **sessional funding** provided by FEI **and administrative support** and encouragement provided through MSAs and/or FEI.

Engagement Between MSA and HA

Similarly, activity implementation also **provided a platform and resources** to support MSA and HA stakeholders to come together, identify shared interests, and develop relationships, **building a foundation for future collaboration and partnership.** HA **engagement around issues of importance to physicians** also furthered MSA-HA relationships.

While all activities featured in qualitative stories involved interactions between MSAs and HAs, **engaging key personnel and undertaking engagement with greater levels of commitment** (based on FEI's adaptation of the IAP2 framework) **appeared to best support relationship building, engagement, and success**. Activities that involved collaboration between physicians/MSAs and key HA personnel were more frequently attributed with strengthening relationships and advancing shared interests than activities that involved engagement with a lower level of commitment (e.g., informing, consulting). For example, the IHA Patient Transportation Committee and VCH Coastal Simulation Program were both guided by **strategic plans or priorities jointly developed through formalized processes and structures** that included both key physician/MSA and HA representatives. In IHA, this involved forming a regional Working Group, which then led to establishing the multi-stakeholder Patient Transportation Committee supported by FEI funding. Similarly, the decision to expand VCH's Coastal Simulation Program was grounded in collaboration between a Steering Committee and MSA Executive to identify shared interests that could be pursued with support from FEI. Further, while FHA's featured Virtual Health activity was physician-led and -developed, participants emphasized the **focus on meaningful engagement** with HA leaders and the hospital foundation **through early and ongoing meetings to garner buy-in and support**, which included securing funding from the hospital foundation to purchase iPads.

In contrast, the featured activities in VIHA encountered **challenges attributed to well-intentioned stakeholders overlooking opportunities to meaningfully identify, engage, and collaborate with key decision-makers**. The VIHA Secure Email activity involved engagement and collaboration between physician participants and lower-level HA staff – in particular IMIT staff – but not with leaders who would have been better positioned to identify and leverage alignment between physician- and HA-led efforts.

MSA Collective Voice

Two featured activities **strengthened and amplified MSA collective voice by providing opportunities for meaningful and deliberate physician/MSA consultation and collaboration** about facility- and regional-level

issues affecting physicians' work environment and patient care. The first, the Patient Transportation Committee in IHA, **created a structure through which physicians were positioned alongside other health system stakeholders** to explore and discuss issues and possible solutions together. The Committee gained traction as the regional authority on patient transportation and ensured that physicians had a seat at the table for planning and decision-making.

The VCH Coastal Simulation Program activity, meanwhile, **built up physicians' capacity to collaborate amongst themselves and with other medical staff** to run simulation scenarios that **generated real-life evidence** informed by interdisciplinary collaboration and input. **Findings were then brought forward to HA leadership to advocate for, and guide, planning and decision-making**. COVID-19 provides a compelling example: LGH 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. This engagement succeeded in setting planning and implementation of a COVID management system in motion.

Quality of Patient Care

All featured activities **aimed to improve patient care or enhance physicians' ability to deliver care**. While it is too soon to assess outcomes for many due to the early stage of implementation and/or indirect effect on patient care, two featured activities have already been credited with supporting improvements to patient care. In FHA, the FEI-funded activity **supported implementation of virtual technologies** to reduce patient-provider contact when in-person care was not required. Not only did this **mitigate against exposure to COVID-19** while maintaining access to quality care, but it also **supported wellbeing by allowing patients to stay connected** with friends and family while isolated in the hospital. Improvements have also been attributed to the Coastal Simulation Program in VCH, which has **enabled workflow optimization** as well as **built skills and confidence among medical staff**, improving the delivery of patient care. For example, simulation training equipped staff to use a mechanical chest compression system that has since improved resuscitation outcomes in the Emergency Department.

Participants of two featured activities emphasized that while engagement can support improvements in patient care, **adequate resources such as funding and personnel are also required** to realize the desired changes. Engagement alone is not enough.

APPENDIX: Supplemental Methodological Information

Objectives

An Evaluation of the FEI is being undertaken to support learning and identification of potential opportunities for improvement as well as to communicate impacts of FEI to stakeholders in relation to the expected outcomes. As part of the evaluation, qualitative story interviews were conducted with physicians, HA representatives, MSA project staff, and external stakeholders to collect rich data on FEI outcomes and develop stories that highlight the impact of MSA activities and processes. Four qualitative stories (which form the basis of this report) were developed to inform interim evaluation findings.

Methodology

Each story focuses on a separate FEI-funded activity and is informed by 3-4 interviews with stakeholders involved in the activity as well as available documents and/or data such as project funding applications, SEAT data, and activity outputs. Interviews (n=14) were 30-60 minutes in length, guided by a highly flexible interview guide, and conducted over telephone between September and November 2020.

Featured activities were purposefully selected to explore and illustrate key challenges and successes of the FEI that were identified through other evaluation activities, particularly qualitative interviews with EPs. Considerations of representation (e.g., HA region, urban versus rural context, facility size) also informed story selection. Interviewees were identified by EPs and each other and included:

Interviewee Type	Number (n)	Proportion (%)
Physicians	7	50%
HA representatives	4	29%
MSA project staff	2	14%
External stakeholders	1	7%
Total	**14**	**100%**

Detailed notes were taken by the interviewer during each interview, and interviews were recorded (with permission) to ensure accurate data capture. Data were thematically analyzed by story and across stories to group and identify emergent themes related to the expected outcomes of the FEI. Findings are similarly reported by story and overall.

Stories are not intended as an assessment of the value or performance of the featured activities or participating stakeholders. Rather, the stories collectively illustrate learnings generated through FEI to date, made possible by participants' generous contributions of time and insight.

Strengths and Limitations

Flexible story and interviewee selection with input from local EPs and other activity participants supported identification of relevant activities and interviewees that reflected a range of experiences with FEI across regions and stakeholder types. Further, the highly flexible interview structure supported the collection of rich data supported by examples and contextual information about key challenges, opportunities, processes, and outcomes associated with each activity, guided by interviewees' own perspectives and experiences.

Primary limitations include the relatively small number of interviews conducted for each story and limited availability of quantitative outcome data given that implementation is early or ongoing for most activities. To mitigate these limitations, extensive efforts (e.g., persistent email and telephone follow-up) were made to identify and include key personnel and stakeholder types who were involved in or affected by each activity. Further, findings for each story were cross-validated across interviews and data sources (e.g., project grant applications) where possible and validated with interviewees. Overall conclusions were then drawn from an analysis of key themes across stories. Nonetheless, findings should be interpreted with the view that progress toward, and achievement of, expected outcomes was largely determined using qualitative data (as expected based on the qualitative methodology employed) and a limited sample size.