

Executive Summary: Interim Report



This is a summary of the interim findings (as of August 13, 2026) from the evaluation of Facility Engagement (FE) outcomes between September 2025 and March 2027, by the [Social Research and Demonstration Corporation](#) (SRDC). The final report will be delivered in March.

Data collection methods: Document review, survey, and review of administrative program data on engagement activities across BC.

Survey participants: 1,562 physicians, other health professionals, and medical/operational leaders, spanning all health authorities.



Question 1

Has FE achieved the outcomes outlined in the Memorandum of Understanding?

Outcome 1 key finding

FE supports engagement within and among MSAs by creating sustainable structures and practical opportunities for connection, shared learning, and collaborative problem-solving.

FE-related collaboration within and across MSAs is perceived as strong, sustainable, and practical.

FE provides recurring structures and practical opportunities for medical staff to connect, share information, build relationships, and work through common challenges, including through a mix of formal and informal, low-barrier opportunities.



Evaluation evidence

Relational and practical value

Activities build trust, psychological safety, a sense of personal accomplishment, and belonging, while supporting communication, operational coordination, project development, shared learning and problem-solving.

Broader and more inclusive participation

FE-supported structures have helped engage previously underrepresented specialties, expand working group and executive membership, welcome new staff, and provide options for people unlikely to join formal forums.

Collaboration across sites

Regional tables and communities of practice enable medical staff to compare challenges, identify shared priorities, and strengthen their collective voice.

Approximately 75% of survey respondents said they belong to a collaborative, patient-centered MSA. Greater familiarity and involvement with FE were associated with higher levels of agreement for the majority of items surveyed: 14 and 16 of 18 items, respectively.



(Scale was between -2 to +2, +2 being the most positive.)

“It’s easier to contact a specialist for a consult if you’ve shared a table with them and chatted about their kids.”
— Nurse practitioner, FE survey

Outcome 2 key finding

FE-supported activities are strengthening MSA and HA engagement, especially where HA partners participate directly and respond to medical staff priorities.

This engagement is strongest where HA partners participate consistently, have appropriate decision-making roles, and respond to medical staff priorities. FE creates forums where MSA and HA partners can exchange information, identify shared priorities, and collaborate on operational or system-level issues.



Evaluation evidence

Shared problem-solving and action

When HA partners participated regularly, FE forums moved beyond information-sharing. Partners helped shape projects, contributed operational perspectives, aligned work with organizational priorities, and collaborated on staffing, resources, policy, communication and continuity of care.

Stronger relationships over time

Repeated engagement supported more open, direct and collaborative relationships. Medical staff felt better heard, while HA partners gained a clearer understanding of site-level realities and could consider priorities earlier in operational or regional planning.

Impact depends on quality of participation

Progress was constrained by limited HA attendance, absent decision-makers, leadership turnover, unclear escalation routes, top-down decisions, inconsistent responses and lack of transparency regarding follow-through.

The majority of survey respondents had seen examples of collaborative decision-making between their MSA and the health authority.

Below: Survey respondents with greater involvement in MSA work reported more positive perception of MSA-HA trust, engagement pathways, and collaboration.

“[FE regional tables such as] the Presidents Council [are] a vital part of how sites understand and engage with senior HA leadership.”
— Physician, FEMS post-claim survey

	Slightly involved	Somewhat involved	Moderately involved	Very involved
I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients	45%	57%	59%	64%
I understand how to engage with the Health Authority through the MSA	41%	57%	64%	76%
I have seen examples of collaborative decision-making between my MSA and the HA	58%	71%	71%	80%

Outcome 3 key finding

FE supports MSA collective voice in health system planning and decision-making. FE supports MSAs and regional groups to gather, organize, and communicate medical staff perspectives. **This collective voice has contributed to planning, implementation, escalation, recruitment, and operational decision-making.**

The final evaluation report will explore more deeply what helps translate the voice of medical staff into action and sustained impact.



Evaluation evidence

Priorities become organized and visible

Structured processes helped medical staff identify shared priorities and bring them forward collectively. Areas included wellness, recruitment/retention, clinical workflows, patient safety, rural resource equity, electronic health records, care coordination and service continuity.

Collective voice informs practical action

In selected cases, medical staff input contributed to recruitment resources, staffing and service-continuity responses, rural patient-transport discussions, transfer-code implementation, workflow redesign and strategies to maintain care closer to home.

Stronger measurement can connect voice to impact

Most survey respondents said their MSA represents member priorities and communicates activities and decisions. A smaller majority reported clear measures of impact, highlighting the need for clearer MSA outcomes, transparent processes, implementation pathways, and feedback.

A majority of survey respondents agreed that their MSA represents members' priorities and collective interests but called for clearer routes from collective MSA voice to action, funding, and implementation.

“Bolstering relationships with admin bodies such as the city ... helps physician staff feel empowered to be part of ... strategic solutions-focused planning. It is also very important the physician voice remains at these tables, so all parties understand the scope of work.”

— Physician, FEMS post-claim survey



Question 2

How has FE helped MSAs and HAs drive meaningful improvements that are aligned with the Quintuple Aim and, ultimately, improve access to care?

FE-supported structures and activities contribute to the [Quintuple Aim](#) most clearly by strengthening provider experience and creating the relationships, channels, and improvement structures that support better care. Evidence related to patient experience, population health, cost, and equity is also present, though its strength and consistency varies.



Provider experience: This is the strongest, most consistently demonstrated area of FE contribution. FE-supported activities strengthen connection, morale, communication, professional confidence, recognition, and participation in meaningful non-clinical improvement work.



Patient experience and access to quality care: FE contributes to patient experience and access directly and indirectly. Some activities have supported new or improved pathways, referral and patient safety processes, patient transfers, service coordination, and care closer to home. In other cases, FE strengthens the relationships and coordination needed to support care.



Population health: These impacts are less directly measurable at this interim stage. However, some FE-supported activities show plausible pathways to population health impact, particularly where they focus on underserved populations, rural access, prevention, continuity of care, or coordination.



Cost and resource use: FE supports more effective resource use when engagement leads to more efficient workflows, reduced duplication, improved coordination, shorter lengths of stay, better use of clinical resources, or fewer avoidable transfers. However, cost and resource-use outcomes are not consistently measured across FE-supported activities.



Equity: FE supports opportunities to advance equity for providers and patients. Examples include rural/regional access work, cultural safety and anti-racism activities, inclusive engagement practices, and efforts to improve care for socially vulnerable populations. At this stage, equity is more often described as an intended outcome than as a consistently measured impact.

Opportunities

Awareness and participation

Increase awareness of FE among less-engaged groups; continue supporting low-barrier relationship-building opportunities that help build trust before operational or clinical issues need to be addressed; and strengthen HA participation in FE-supported engagement forums, particularly by encouraging consistent attendance from partners.

Administration and operations

Clarify roles and expectations across MSAs, program/project managers, Engagement Partners, and HA partners and reduce administrative burden where possible.

Outcomes tracking and communication

Build more consistent MSA outcome tracking for selected FE-supported activities and improve feedback loops so medical staff can see how their input has influenced planning, decisions, project design, or operational changes.

Moving beyond engagement

Clarify pathways from engagement to action and identify promising activities or projects that may be ready for spread, sustainability planning, or transition to HA or system-level support.



Next steps in the evaluation

Thematic case studies and a second round of program data review (fall 2026), a reflection session with FE (January 2027), and a final report (March 2027).