



Evaluation of the Facility Engagement Initiative

Interim Report

August 13, 2026

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ACRONYMS

Acronym	Full Term
AR	Annual Review (previously SRRP – Site Review and Reporting Process)
BC	British Columbia
BCEHS	BC Emergency Health Services
CME	Continuing Medical Education
EHR	Electronic Health Records
ER	Emergency Room
ERP	Emergency Room Physician
FE	Facility Engagement
FEMS	Facility Engagement Management System
HA	Health Authority
HAE	Health Authority Engagement
JCC	Joint Collaborative Committee
MOU	Memorandum of Understanding
MRP	Most Responsible Physician
MSA	Medical Staff Association
OAT	Opioid Agonist Therapy
PACU	Post Anaesthesia Care Unit
QI	Quality Improvement
RARR	Regional Annual Review and Reporting
SEAT	Site Engagement Activity Tracker
SPH	Saanich Peninsula Hospital
SRDC	Social Research and Demonstration Corporation
SSC	Specialist Services Committee

GLOSSARY

Doctors of BC: A democratic association representing physicians in British Columbia. Doctors of BC works with members, government, Health Authorities, and other partners to support physicians' leadership in delivering and improving patient care.

Facility Engagement (FE): A Specialist Services Committee initiative that provides funding, resources, structures, and supports for facility-based Medical Staff Associations and Physician Engagement Societies to strengthen engagement among medical staff and with Health Authorities, with the goal of improving care delivery and the clinical work environment.

Formal engagement activities: Structured engagement activities with a defined purpose, process, or decision-making function. Examples include MSA meetings, executive meetings, working groups, governance committees, project review processes, strategic planning sessions, Health Authority meetings, and regional tables.

Health Authorities (HAs): Regional or provincial organizations responsible for planning, delivering, and managing publicly funded health services in British Columbia. The six Health Authorities in British Columbia are Fraser Health, Interior Health, Island Health, Northern Health, Vancouver Coastal Health (including Providence Health Care), and the Provincial Health Services Authority.

Informal engagement activities: Lower-barrier engagement activities intended to build relationships, trust, collegiality, and participation outside formal governance or decision-making structures. Examples include lunches, wellness events, social gatherings, peer connection activities, and other opportunities for medical staff to connect.

Joint Collaborative Committees (JCCs): Collaborative committees, unique in Canada, established through agreements between Doctors of BC and the Government of British Columbia to support physicians, government, HAs, and other partners to work together on health system improvement. The JCCs include the Specialist Services Committee, Family Practice Services Committee, Shared Care Committee, and Joint Standing Committee on Rural Issues.

Medical Staff Association (MSA): The formal body representing medical staff at a facility in BC. MSAs may carry out both FE-supported engagement activities and other activities related to governance, funds, administration, or routine MSA business.

Memorandum of Understanding (MOU): A written agreement that describes shared commitments, roles, and expectations between parties. In the context of FE, the MOU supports the shared commitment to meaningful local and regional engagement among facility-based medical staff and HAs.

Ministry of Health: The Government of British Columbia ministry responsible for the provincial health system, including health policy, strategic direction, and oversight of publicly funded health services.

Physician Engagement Society: Acts as a hospital MSA's legal structure to hold funds and contracts and/or provide liability protection for its executives; in most cases, the executive of a MSA and the executive of an FE Physician Engagement Society are the same individuals.¹

Physician Master Agreement: The negotiated agreement between the Government of British Columbia and Doctors of BC that sets out the relationship and economic arrangements between the parties, including funding arrangements that support the Joint Collaborative Committees.

Quintuple Aim: A health system improvement framework developed by the Institute for Healthcare Improvement and used by the JCCs. In this evaluation, the JCC Quintuple Aim refers to provider experience, patient experience, population health, per capita cost, and equity.

Specialist Services Committee: One of four Joint Collaborative Committees (JCCs) established in 2006 to support Doctors of BC, the Government of BC, and provincial Health Authorities to collaborate on the delivery of specialist services and support improvement of the specialist care system in BC.

¹ For the most part, we use the term MSA to refer to both MSAs and Physician Engagement Societies in this report.

WHAT IS THE FACILITY ENGAGEMENT (FE) INITIATIVE?

Established in 2014 and guided by the Specialist Services Committee (SSC), the Facility Engagement Initiative is a provincial initiative to support meaningful consultation and collaboration among facility-based medical staff and health authorities (HAs) in British Columbia (BC). Its goal is to strengthen communication and relationships and create effective processes for working collaboratively on shared priorities for improving the clinical work environment and patient care delivery, alleviating hospital pressures, addressing regional and system challenges, and bolstering wellness and workplace culture.

FE's aims/expected outcomes

- Improve engagement within and among MSAs
- Improve MSA and HA engagement
- Enhance MSA collective voice in health system planning and decision making

To achieve its goal, FE:

- Provides funding and resources to Medical Staff Associations (MSAs);
- Supports local and regional structures and processes for effective interactions between HAs and MSAs; and
- Works with HA leaders to support shared understanding and partnership opportunities with MSAs.

Two main groups engage in FE:

1. Physicians and medical staff who provide a voice for what patients and physicians need; and
2. Local and regional HA leaders and administrators who provide a voice for what is possible to achieve in the organization.

Each HA in BC has confirmed its commitment to support greater engagement and collaboration with physicians through a Memorandum of Understanding (MOU). The MOU, in turn, forms the basis of a shared commitment to local and regional engagement on the part of Doctors of BC, the Ministry of Health, and HAs as part of the Physician Master Agreement.

Within its first 10 years of operation, FE engaged six HAs, 76 MSA across 85 facilities and six provincial programs, and over 6,500 physicians. Underpinning FE is the belief that working together helps everyone involved solve problems faster, make better decisions, and achieve more.^{2,3}

² Engaging to Improve BC Health Care (https://facilityengagement.ca/sites/default/files/AboutFE/FEAcrossBC2024_RJuly2024.pdf).

³ About Facility Engagement (<https://facilityengagement.ca/about-facility-engagement>).

WHY AND HOW IS FE BEING EVALUATED?

SSC has engaged the Social Research and Demonstration Corporation (SRDC) to conduct an outcomes evaluation of the FE initiative between September 2025 and March 2027. The evaluation is currently examining the extent of FE’s achievement of its main expected MOU outcomes and impact aligned with the JCC Quintuple Aim,⁴ as reflected in the overarching evaluation questions guiding this work.

Evaluation questions

1. What is the impact of the FE initiative against its intended outcomes?
 - a. To what extent has FE contributed to improved engagement within and across MSAs?
 - b. To what extent has FE contributed to improved MSA and local and regional HA engagement?
 - c. To what extent has FE contributed to enhancing MSA collective voice in health system planning and decision-making?
2. How has FE helped MSAs and HAs drive meaningful improvements related to the JCC Quintuple Aim and, ultimately, improved access to quality care?

This **interim evaluation report** presents an update on evaluation activities and emerging results to date.

METHODS

The report draws on three data sources/methods, which together help understand FE’s design and context, assess emerging evidence related to FE’s intended outcomes, and identify early patterns in how FE-supported engagement contributes to the JCC Quintuple Aim and access to quality care.

1. Document review

Key FE documents—including the JCC Quintuple Aim Framework and other background documents describing FE’s structure, goals, and intended outcomes—were reviewed to inform the evaluation plan, survey development, ensure alignment of data analysis with FE’s intended outcomes and the JCC Quintuple Aim, and interpretation of findings.

⁴ The Quintuple Aim is a comprehensive approach to advancing healthcare quality developed by the Institute for Healthcare Improvement. Since 2025, JCC has been measuring impact against a version of the Quintuple Aim adapted to the JCC/BC context (additional refinements by JCC are ongoing). All references to the Quintuple Aim in this report refer specifically to the JCC adaptation. Further details are available here: <https://www.collaborateonhealthbc.ca/about-us/our-principles/>.

2. FE medical staff and HA partner survey⁵

The FE medical staff and HA partner survey was administered online from February 25 to March 23, 2026 to gather perspectives on FE processes, engagement within and across MSAs, MSA and HA engagement, communication, collaboration, decision-making, overall satisfaction, perceived value and impact related to the JCC Quintuple Aim, and improved access to quality care.

Survey features

Minimal respondent burden: The survey took approximately 10 minutes to complete. Most questions were closed-ended while two open-ended questions provided qualitative context about meaningful FE activities, experiences, and opportunities for improvement.

Validated scales: The survey included three validated or widely used scale-based measures relevant to provider experience and engagement:

1. **Edmondson's Psychological Safety Scale** to assess psychological safety, defined as whether respondents perceive their work environment as safe for interpersonal risk-taking. The selected items assess whether people feel able to raise problems, take interpersonal risks, rely on team members not to undermine their efforts, and feel that their skills and talents are valued and used.
2. **Communication Subscale adapted from Call et al.⁶** to assess communication in health care settings. The items capture whether information is shared clearly, consistently, and respectfully, including whether respondents feel heard and understood. Strong scores reflect communication environments that support coordination, speaking up, patient safety, and team effectiveness.
3. **Maslach Burnout Inventory Human Services Survey for Medical Personnel Personal Accomplishment Subscale** to assess personal accomplishment. The selected items align with the provider experience dimension of the JCC Quintuple Aim by capturing feelings of competence and successful achievement in one's work.

Target audience: The survey was targeted to individuals with different types of involvement with FE, including physicians, other medical staff, and HA partners. The survey used skip logic so that respondents received questions relevant to their role, level of involvement, and relationship to FE. All respondents were asked demographic questions, questions about their familiarity with FE and level of involvement in the work of the MSA, and open-ended questions. Respondents who indicated that they were not health care providers and did not hold a formal HA leadership role were directed to the end of the survey. Respondents who reported being "not at all involved" in the work of the MSA did not answer MSA-level questions. Questions about psychological safety, communication, and personal accomplishment were shown only to physician respondents. All responses were anonymous.

Distribution/promotion: Survey invitations were emailed to 6,100 MSA contacts and 149 HA contacts. The survey was also promoted through a website banner with a direct survey link and through outreach to individuals with active Facility Engagement Management System (FEMS) accounts.

⁵ The survey communication materials and questionnaire are located in Appendix C. Detailed survey results are located in Appendix D.

⁶ Call, M., Qeadan, F., Tingey, B., Morrow, E., Webber, D., Hamilton, B., & Locke, A. (2023). *Measuring provider well-being: Initial validation of a brief engagement survey*. BMC Health Services Research, 23, Article 432.

Closed-ended survey questions were analyzed using Excel and Stata. Excel was used for data cleaning, tabulation, and descriptive summaries. Stata was used for statistical analyses and comparisons across groups, including by HA, role, familiarity with FE, and level of involvement in the work of the MSA. Agreement items were grouped into three categories: disagree or strongly disagree, neither agree nor disagree, and agree or strongly agree. Where noted, chi-square tests were used to examine whether response distributions differed across groups. Scale scores were analyzed using group means, with Welch's ANOVA used where appropriate to test whether scores differed across levels of familiarity or involvement. All graphs represent significant findings. Open-ended survey responses were analyzed thematically to identify patterns related to meaningful FE activities, perceived impacts, and opportunities for strengthening FE.

Survey sample

The survey achieved the largest response to an FE survey to date, with 1,562 respondents (25% response rate). Respondents also provided substantial open-ended feedback: 672 responses to the question asking which MSA activities or changes had been most meaningful in improving engagement, collaboration, or access to quality care, and 536 responses to the question asking respondents to share additional experiences with FE or identify one thing they would change. This high level of open-ended response provides an additional indicator of respondent engagement with the evaluation and offers rich qualitative context for interpreting the quantitative findings.

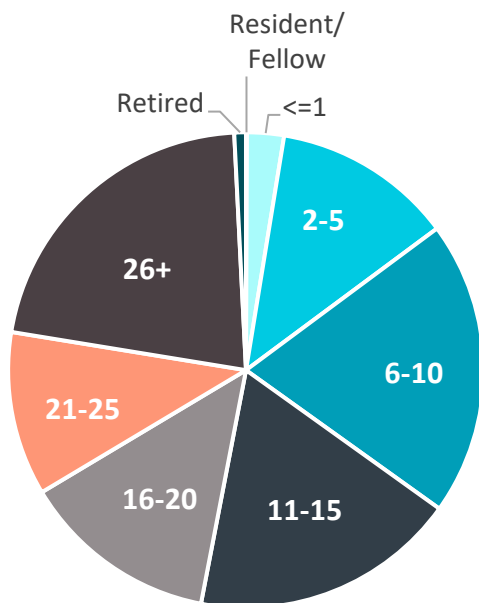
As described in Table 1, most survey respondents were physicians, including family (35 per cent) and specialist (52 per cent) physicians. The sample also included other health professionals (10 per cent), such as midwives, nurse practitioners, dentists, and respondents who selected "another provider type," as well as a smaller group of respondents who were not health care providers (3%). Respondents represented all six HAs. Among respondents with complete HA and provider-role data, approximately one-quarter were from Island Health (24 per cent), while about one-fifth each were from Fraser Health (21 per cent), Vancouver Coastal Health (VCH) & Providence Health Care (PHC, 20 per cent), and Interior Health (19 per cent). Smaller proportions were from Provincial Health Services Authority (PHSA, 10 per cent) and Northern Health (5 per cent).

Table 1 FE sample by HA and profession

Health Authority	Family physician	Specialist physician	Other health professional	Not a health care provider	HA totals
Interior	126	131	37	8	302
Fraser	104	179	30	7	320
Island	139	190	36	11	376
Northern	44	31	6	2	83
PHSA	25	100	25	9	159
Vancouver Coastal & Providence Health Care	105	182	27	2	316
<i>Role totals</i>	<i>543</i>	<i>813</i>	<i>161</i>	<i>39</i>	<i>1556</i>

Note. Other health professionals include midwives, nurse practitioners, dentists, and respondents who selected “another type of health care provider.”

As shown in Figure 1, the sample included respondents across all career stages, indicating that the survey captured perspectives from both newer and more experienced members of medical staff.

Figure 1 FE sample by years of practice

Leadership roles also varied across the sample: 77 per cent reported no formal HA leadership role, 19 per cent reported a formal medical leadership role, and 4 per cent reported a formal operational leadership role. Formal medical and operational leaders were present across all HAs. Formal medical leadership was concentrated among physicians: 95 per cent of formal medical leaders were physicians. Formal operational leadership was more evenly distributed across respondent groups, including other health professionals (38 per cent), physicians (33 per cent), and respondents who were not health care providers (29 per cent).

3. Administrative program data review and analysis

The administrative program data review included four main FE data sources shared by the FE team:

- **Annual Review (AR) submissions:** Sample of MSA-level reflections on activities, achievements, challenges, HA engagement, and impacts over the reporting period.
- **Regional Annual Review and Reporting (RARR) submissions:** Regional-level reflections on FE-supported work, including regional tables, cross-site initiatives, HA engagement, and regional priorities.
- **Site Engagement Activity Tracker (SEAT) entries:** Sample of activity-level descriptions of selected FE-supported projects and engagement activities, including their goals, participants, implementation experiences, and reported results. The sample included 100 activities from the current year that had results to report and was selected to reflect diversity across both types of engagement activities and HAs.
- **Facility Engagement Management System (FEMS) data:** Activity descriptions, which provided a broad picture of the types of activities supported through FE, and post-claim survey comments, which consisted of physician feedback following participation in FE-supported activities.

Together, these sources were reviewed to describe the scope and types of FE-supported activities, examine how activities aligned with FE's intended outcomes, and identify early examples of contribution to JCC Quintuple Aims. Findings from these sources were analyzed thematically using Ascribe and supplemented by manual review where source documents (e.g., PDF attachments), required closer inspection. Findings were then synthesized across data sources where common patterns emerged.

LIMITATIONS

Possible limitations of the evaluation include the following:

- **Administrative data reviewed:** The interim analysis drew on several administrative data sources, including AR, RARR, SEAT, and FEMS, which differ in format, level of detail, and reporting purpose. These sources were used in complementary ways to identify patterns, mechanisms, and illustrative examples.

SEAT was used to examine a manageable sample of approximately 100 FE-supported activities in greater depth, rather than conducting detailed qualitative review of the roughly 2,500 activities available through FEMS. SEAT findings should therefore be interpreted as illustrative examples of activity goals, implementation experiences, and reported results, rather than as an exhaustive account of FE-supported activity.

AR and RARR submissions reflect information reported by MSAs and regional structures and may be influenced by the reporting templates and the information respondents chose to emphasize. In particular, the AR design may have encouraged sites to emphasize one engagement subdomain even where activities contributed to multiple outcomes.

- **Measuring downstream effects:** Many FE-supported activities are intended to strengthen engagement, collaboration, and other conditions that support future improvement. Effects on patient experience, access, population health, equity, and cost may emerge over time or may not be measured consistently at the activity level. The report therefore distinguishes among demonstrated outcomes, activity-specific examples, emerging impacts, and enabling conditions.
- **Survey findings:** Survey findings provide a respondent-level perspective rather than a census of everyone affected by FE. Respondents varied in their familiarity with FE and involvement in MSA work, and skip logic resulted in different sample sizes across survey items and scales.
- **Interim findings:** As this is an interim report, findings should be interpreted as emerging. Additional administrative and financial data analysis, thematic case studies, and a reflection session with the FE team will deepen and triangulate the findings for the final report.

WHAT HAS BEEN LEARNED THROUGH THE EVALUATION TO DATE?

This section presents emerging findings from the first phase of the FE evaluation. We identify the main patterns emerging across sources, where the evidence is strongest, and where further exploration is needed. The findings are organized around the two evaluation questions, the first related to FE's impact against MOU outcomes and the second related to the JCC Quintuple Aim Framework. In addition, a summary of the types of FE-supported activities identified through the administrative data review is provided in Appendix B.

Across both evaluation questions, a key finding is that FE was valued not only for funding activities but also for protecting the time, space, and legitimacy medical staff need to participate in improvement work. Support includes activities such as relationship-building, strategic planning, quality improvement (QI), recruitment and retention, HA engagement, and physician-led efforts to improve care delivery and the work environment. The sections below interpret these activity patterns alongside findings from SEAT, AR, RARR, FEMS post-claim comments and open-ended survey responses.

EVALUATION FINDINGS OF FE BASED ON MOU OUTCOMES

Evaluation take-aways

FE-supported structures and opportunities support all three intended outcomes of the initiative:

- Outcome 1: FE supports engagement within and among MSAs by creating recurring structures and practical opportunities for connection, shared learning, and collaborative problem-solving.
- Outcome 2: FE-supported activities are strengthening MSA and HA engagement, especially where HA partners participate directly and respond to medical staff priorities.
- Outcome 3: FE supports MSA collective voice in health system planning and decision-making.

FE-supported engagement was more likely to move from connection and discussion toward action when several enabling conditions were present.

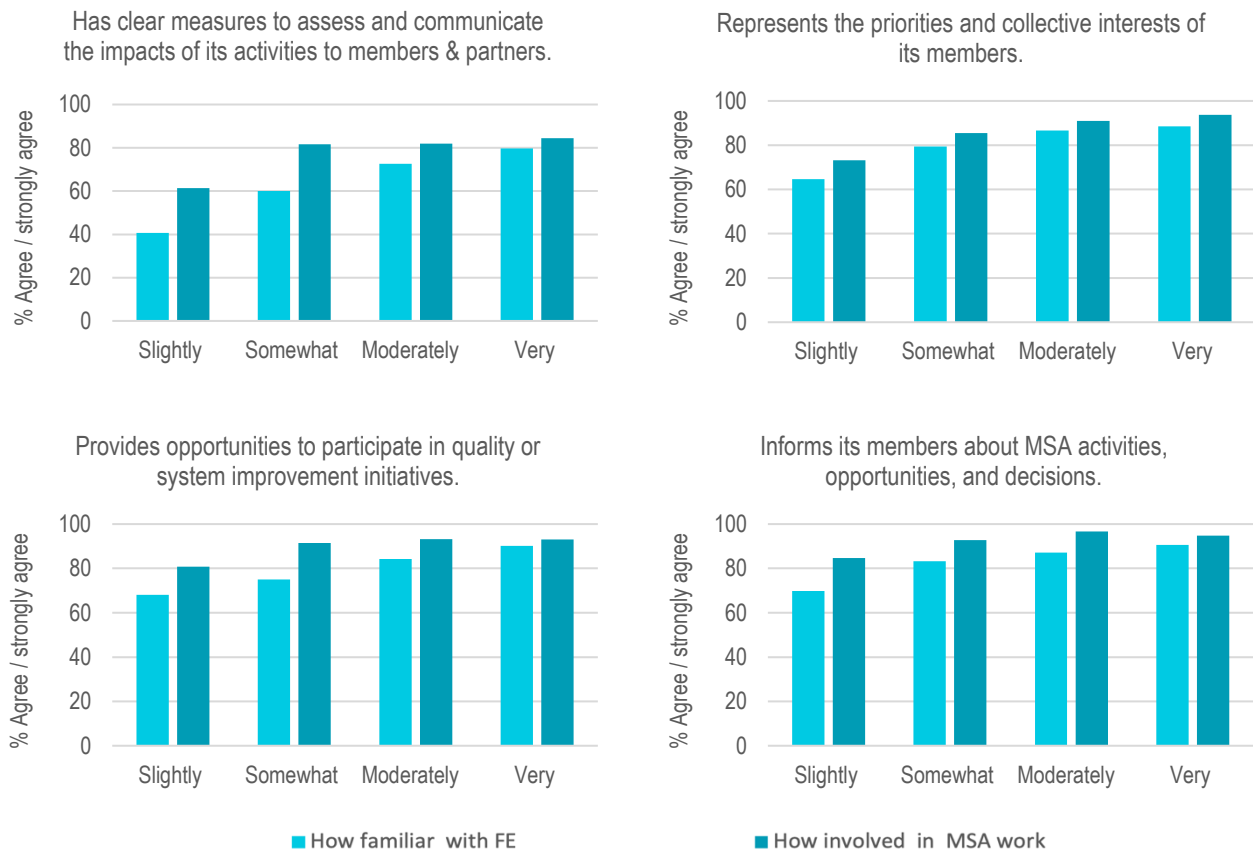
FE-supported structures and opportunities support all three intended outcomes

Across the sources reviewed to date, FE-supported structures and activities provide evidence of contribution to all three intended outcomes: strengthening engagement within and across MSAs, improving MSA and HA engagement, and enhancing MSA collective voice in health system planning and decision-making.

- The strongest evidence relates to the creation of recurring engagement structures, relationship-building opportunities, shared learning spaces, and more direct communication channels between medical staff and local or regional HA partners.
- Evidence of influence on planning and decision-making is also present, particularly where engagement structures connect medical staff perspectives to leaders with operational or regional decision-making roles.
- The extent of influence varies across sites and regions, and some examples show that HA capacity, leadership continuity, and follow-through remain important conditions shaping what FE-supported engagement can achieve.

The quantitative survey findings provide a broader respondent-level anchor for these patterns (see Figure 2). Agreement increased with familiarity with FE and involvement in MSA work, suggesting that more familiar and involved respondents were more likely to report positive experiences of representation, communication, and participation. These results support the qualitative finding that FE supports the creation of the structures and opportunities through which medical staff can participate in engagement, planning, and improvement work.

Figure 2 Perceived MSA representation, communication, participation, and impact measurement increased with familiarity and involvement



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

Outcome 1: FE supports engagement within and among MSAs by creating recurring structures and practical opportunities for connection, shared learning, and collaborative problem-solving

FE-supported engagement is often most effective when it creates consistent and practical spaces for medical staff to connect, share information, and work through shared challenges. Across the sources reviewed, these spaces included formal structures, such as MSA meetings, working groups, governance committees, strategic planning sessions, educational rounds, Continuing Medical Education (CME) and Quality Improvement (QI) activities, and regional tables. They also included informal and lower-barrier activities, such as lunches, wellness events, social gatherings, and peer connection activities.

Recurring formal forums and low-barrier activities create the foundation for sustained engagement

Administrative data show that FE supported both recurring formal forums and lower-barrier opportunities for connection, providing multiple ways for medical staff to participate and remain engaged over time. These activities often served both relational and practical purposes. They helped medical staff build trust, reduce isolation, strengthen morale, and connect across departments, specialties, and sites. At the same time, they created structured opportunities for communication, operational coordination, policy updates, project development, shared learning, and collaborative problem-solving. In this way, FE-supported engagement was not limited to either social connection or formal governance; rather, sustained engagement appeared to depend on both.

The FEMS Post-Claim Survey comments add physician perspectives on why these opportunities matter in practice. Physicians described FE-supported activities as “much needed meetings to get important information and discussion across,” “great participation and community building with different physicians,” and “the best opportunity to connect to discuss current healthcare relevant matters.” One physician who had recently joined a site described FE-supported luncheon sessions as helping them “see new faces and meet colleagues in different departments,” adding that these activities made their transition to a new hospital more positive and that they were glad they had decided to start practicing there.

The administrative data also suggest that these structures helped broaden participation. Examples included growth in working group or executive membership, representation from previously unrepresented specialties, more inclusive meeting structures, and activities designed to reach medical staff who may not participate in more formal settings. At the regional level, tables and communities of practice extended this function across sites by helping medical staff compare local challenges, identify shared priorities, and build a stronger regional voice.

Collaboration within and across MSAs is perceived to be strong

Open-ended survey responses reinforce that the most meaningful FE-supported activities were often those that created regular, practical opportunities for physicians and other medical staff to connect across departments, specialties, sites, and professional roles. Respondents identified formal and informal activities as important mechanisms for improving engagement and collaboration. These activities were described as helping physicians work less in silos, build collegial relationships, welcome new staff, support informal mentorship, and create space for difficult or shared issues to be discussed.

“Bringing the hospital together through social activities help to improve cross-discipline QI opportunities and makes you feel part of the medical home/hospital.”

– Specialist Physician & Medical Leader, FE Survey

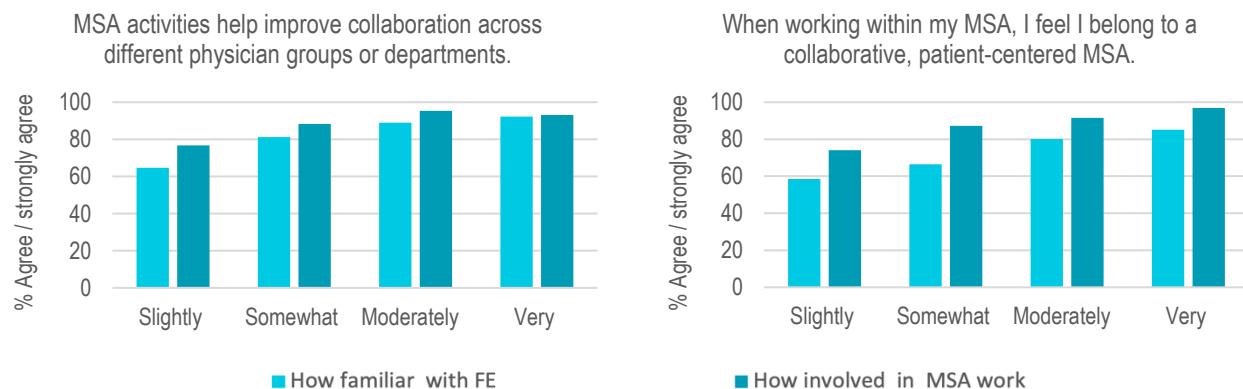
“It’s easier to contact a specialist for a consult if you’ve shared a table with them and chatted about their kids.”

– Nurse Practitioner, FE Survey

Several respondents emphasized that informal and formal recurring engagement spaces matter because they make participation easier and help build trust before clinical or operational issues arise. For example, respondents highlighted lunches, dinners, and social events as ways to bring together physicians who may not otherwise interact in routine clinical work.

Quantitative survey results also support the finding that FE contributes to engagement within and across MSAs, especially as familiarity with FE and involvement in the MSA increased (see Figure 3). Most respondents agreed that MSA activities help improve collaboration across different physician groups or departments, and three-quarters agreed that they belong to a collaborative, patient-centered MSA. In addition, most reported being as involved in the work of their MSA as they wanted to be. Together, these examples suggest that FE is supporting engagement not only through discrete events or projects but also through repeated opportunities for connection, trust-building, and shared learning. These structures create the foundation for more sustained collaboration within and among MSAs.

Figure 3 Perceived collaboration and belonging increased with familiarity and involvement



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

SITE HIGHLIGHT**Strengthening Site-Level Engagement Through Recurring MSA and HA Meetings: Saanich Peninsula Physician Society (SPPS)**

The Saanich Peninsula Physician Society created recurring opportunities for MSA leadership, medical staff, and Island Health partners to communicate, identify shared priorities, and respond to site-level challenges. Quarterly Saanich Peninsula Hospital (SPH) Admin and MSA Executive Meetings provided a structured forum for open communication and shared problem-solving with Island Health executives, while related activities supported Continuing Medical Education, member meetings, social representative roles, enhanced medical staff communication, and coordinated response to staffing pressures.

Promoting engagement and health system impacts through FE:

- *Provider experience, physician voice, and collaborative decision-making:* Quarterly SPH Admin and MSA Executive Meetings included more than 10 participants, including Island Health executives. These meetings strengthened trust, amplified physician voice, supported policy updates or changes, and provided a funded avenue for physicians to participate in planning sessions, working groups, and consultations where alternate funding was not available.
- *Inclusive participation and member engagement:* SPPS and MSA Member Meetings averaged more than 20 participants and provided an inclusive forum for members, HA representatives, and FE partners to share updates, raise concerns, and collaborate.
- *Quality improvement culture and evidence-informed practice:* Site-specific CME sessions averaged 20 or more participants per session, enhanced clinical knowledge, supported evidence-based practice, and strengthened collaboration across departments.
- *Community, belonging, and feeling valued:* Annual Awards and Year-End Celebration activities brought together approximately 90 physicians, staff, and HA partners to recognize contributions, welcome new team members, and strengthen morale. A South Island MSA and HA barbecue had more than 200 attendees from across South Island sites, strengthening regional relationships, awareness of system-wide challenges, and connection beyond individual sites.
- *Patient experience, continuity, and safety:* During a Most Responsible Physician (MRP) staffing crisis, coordinated communication among MRPs, Emergency Room Physicians (ERPs), and Island Health leadership helped maintain patient attachment, reduce the risk of unassigned patients, sustain physician engagement, and mitigate the crisis without significant disruption to patient care or adverse patient outcomes.

Outcome 2: FE-supported activities are strengthening MSA and HA engagement, especially where HA partners participate directly and respond to medical staff priorities

The document review findings provide consistent evidence that FE-supported activities build communication and collaboration between MSAs and HA partners.

HA participation strengthens engagement when partners are present and responsive

FE-supported activities created opportunities for MSAs, Physician Societies, and HA partners to engage around shared priorities. These opportunities included recurring meetings with HA leaders, project review processes, operational discussions, recruitment and retention activities, emergency department and hospitalist workflow improvements, wellness and recognition activities, patient-care continuity planning, and regional councils or tables.

The strongest examples involved regular HA participation, clear routes for medical staff input, and HA partners with the role clarity, authority, and capacity to respond. In these cases, FE-supported forums helped move engagement beyond information-sharing toward shared problem-solving. Administrative data described HA partners helping shape project direction, contributing operational perspectives, supporting alignment with organizational priorities, participating in implementation planning, and working with medical staff on staffing pressures, resource allocation, policy updates, communication challenges, and patient-care continuity.

“Facility Engagement has been an important mechanism for strengthening collaboration between physicians and the health authority. It provides a structured forum to discuss operational challenges, identify improvement opportunities, and align priorities that ultimately benefit patient care.”

– Operational Leader, FE Survey

Several examples also suggest that repeated engagement can shift the quality of MSA and HA relationships over time. Some submissions described relationships becoming more open, direct, and collaborative, with medical staff feeling more heard and HA partners better able to understand site-level realities. These relationship shifts are important because they create the conditions for medical staff priorities to be discussed earlier, more constructively, and in closer connection with operational or regional planning.

FE-supported forums create opportunities for physicians and HA partners to connect and engage

Physicians described FE-supported activities as opportunities to meet HA partners, make connections around projects and working groups, and engage with senior leadership. One physician described the Presidents Council as “a vital part of how sites understand and engage with senior HA leadership.” Another described a HA project as “definitely being moved along” because the physician was able to engage and be compensated.

Open-ended survey responses provide further evidence that respondents value activities that create meaningful dialogue between physicians, MSAs, and HA partners. Respondents described regular

meetings with management, MSA collaboration, discussions with HA partners, collaborative planning processes, and opportunities to participate in senior leadership tables as meaningful ways to improve engagement and collaboration. One HA partner noted that being regularly invited to meetings helped promote engagement, collaboration, and trust.

MSA and HA engagement is meaningful but uneven

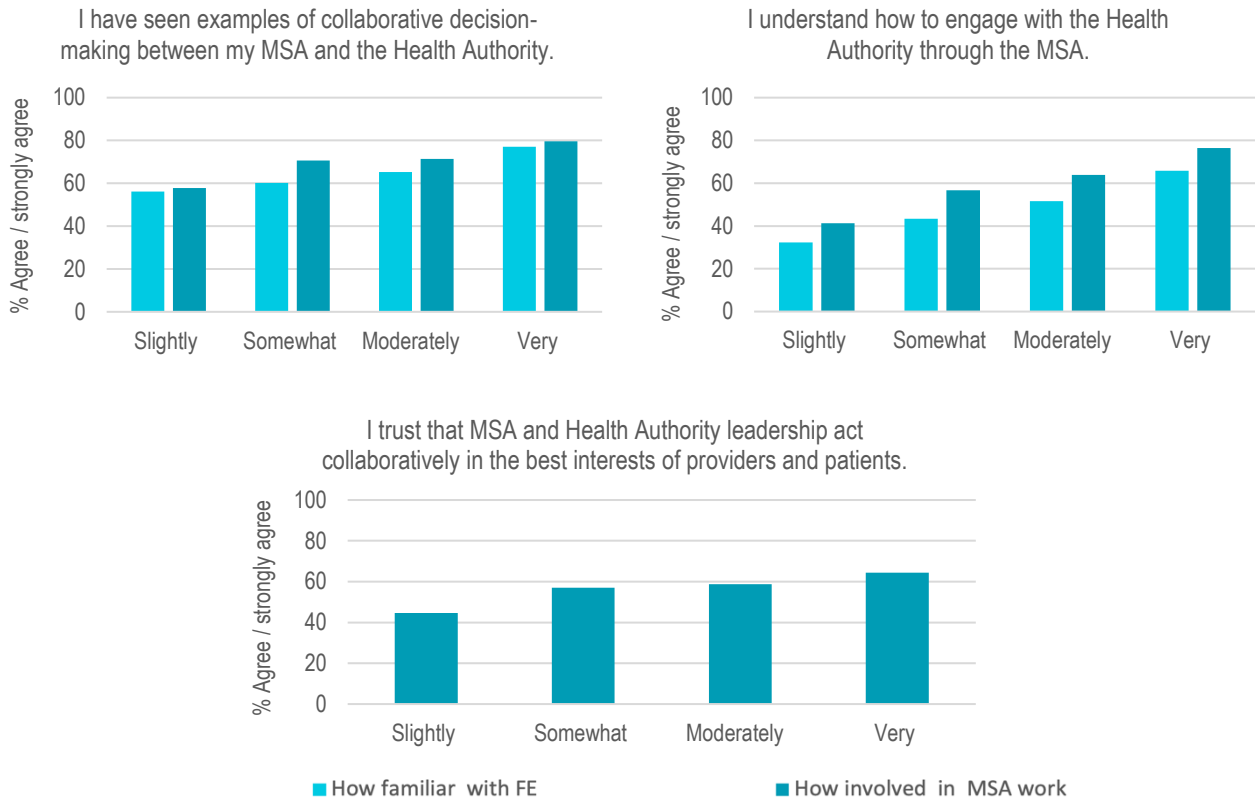
The FE survey provides a broader respondent-level perspective on MSA and HA engagement. Open-ended responses show that respondents valued activities that created meaningful dialogue between physicians, MSAs, and HA partners. Respondents identified regular meetings with management, MSA collaboration, discussions with HA partners, collaborative planning processes, and opportunities to participate in senior leadership tables as meaningful ways to improve engagement and collaboration. One HA partner noted that being regularly invited to meetings helped promote engagement, collaboration, and trust.

At the same time, the quantitative findings show that MSA and HA engagement is more mixed than engagement within MSAs. A majority of respondents agreed that they had seen examples of collaborative decision-making between their MSA and the HA. However, fewer agreed that MSA and HA leadership act collaboratively in the best interests of providers and patients, or that they understand how to engage with the HA through the MSA. Nevertheless, levels of agreement increase significantly as familiarity with FE and/or involvement with the MSA increased (see Figure 4).

Qualitative survey responses echoed this mixed pattern. While many respondents described FE as a helpful structure for building relationships and engaging with administrative partners, others identified barriers such as limited HA attendance, lack of decision-maker participation, leadership turnover, unclear escalation routes, top-down decision-making, insufficient follow-through, and inconsistent responses to medical staff concerns.

Together, these findings suggest that FE provides the forum, relationships, and structure for MSA and HA engagement, but its impact depends on the consistency and quality of HA participation. Engagement is strongest when HA partners participate regularly, listen and respond to medical staff input, and have sufficient authority and capacity to act on shared priorities.

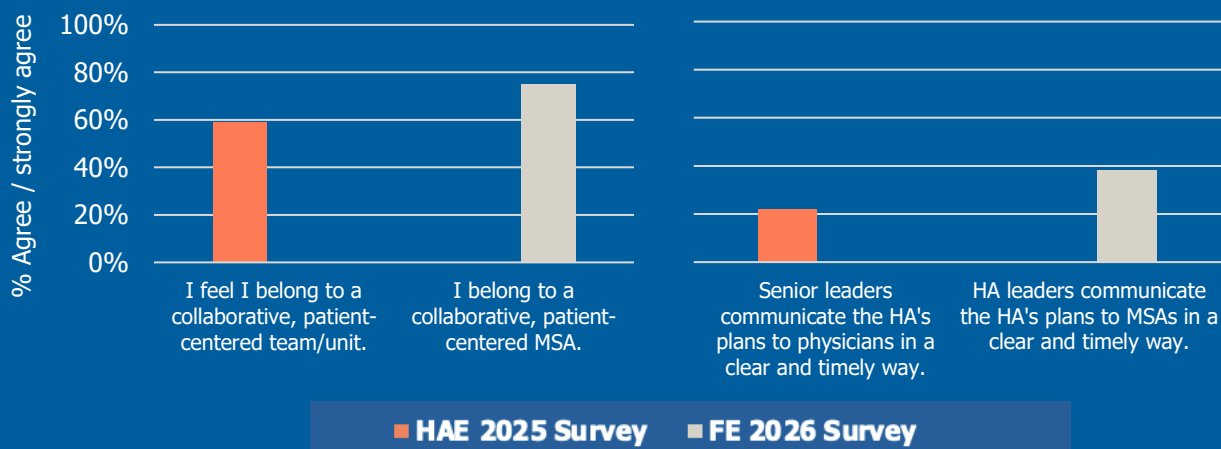
Figure 4 Perceived MSA–HA collaboration, trust, and engagement pathways increased with familiarity and involvement



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

FE survey respondents report stronger collaboration and communication than broader HAE survey respondents

The FE survey included two items with wording similar to items from the 2025 Doctors of BC HA Engagement (HAE) survey⁷, answered by physician respondents only for both surveys, providing useful contextual comparison. Results from the FE survey reflected 16 percentage points stronger agreement on both items. Among physician respondents who were at least somewhat involved in FE, 75 per cent agreed that they belong to a collaborative, patient-centred MSA, compared with 59 per cent of physician respondents in the HAE survey who agreed that they belong to a collaborative, patient-centred team or unit. Similarly, 38 per cent of FE survey physician respondents agreed that HA leaders communicate the HA's plans to MSAs in a clear and timely way, compared with 22 per cent of physician respondents in the HAE survey who agreed with a similar item about senior leaders communicating HA plans for physicians.



These results should be interpreted as contextual rather than as a direct comparison of equivalent measures, given differences in wording, sample, and context. Nonetheless, given the 16 percentage point difference for both items, these findings suggest that FE respondents reported a stronger sense of belonging to a collaborative, patient-centred structure and more positive views of HA communication than respondents to the broader HAE survey. At the same time, the MSA belonging item remained more positive than the HA communication item, reinforcing the broader evaluation finding that MSA-level engagement is a relative strength while HA communication and engagement remain important areas for continued improvement.

Outcome 3: FE supports MSA collective voice in health system planning and decision-making

FE supports MSAs, Physician Societies, and regional groups to gather, organize, and communicate medical staff perspectives.

⁷ The Doctors of BC HAE Survey (www.doctorsofbc.ca/advocacy-policy/engagement/health-authority-engagement-surveys) provides a forum for physicians to share their thoughts and feelings about engagement and interaction with their HA and/or local hospital. The feedback informs Drs of BC work and enables them to advocate on behalf of their members.

MSAs are using structured processes to identify and organize medical staff priorities, contributing to planning, implementation, and escalation in selected cases

Medical staff used facilitated discussions, surveys, strategic planning workshops, working groups, AGMs, executive meetings, regular site forums, and regional tables to identify shared priorities and bring them forward to HA partners and other decision-making spaces.

These processes helped medical staff move from individual concerns toward more organized collective voice. Priorities identified through FE-supported processes included physician wellness, recruitment and retention, emergency department workflow, hospitalist models, learner education, orientation for new physicians and locums, patient safety, rural resource equity, electronic health records, communication with HA leadership, care coordination, and service continuity. In some cases, these priorities led to more formal structures or tools, such as terms of reference, new working groups, clearer executive roles, communication processes, recruitment materials, documented escalation pathways, department-specific plans, workflow redesign, or regional proposals.

At the regional level, FE-supported processes helped medical staff compare challenges across sites, build unity and confidence, and communicate priorities more cohesively to HA leaders and system partners. These regional processes supported knowledge sharing beyond basic information exchange and, in selected cases, contributed to practical planning and implementation. Examples included physician input shaping recruitment resources, coordinated responses to staffing or service continuity challenges, data-informed discussions about rural patient transport, improved implementation of transfer codes, and exploration of strategies to maintain care closer to home.

Physicians report strong perceived representation, with room to strengthen impact measurement

The evidence indicates that FE helps translate individual physician and medical staff experience into more organized input on planning, recruitment, and system improvement. Physician-level comments from the FEMS Post-Claim Survey emphasized that relationships with administrative partners can support more meaningful participation in strategic and solutions-focused planning, especially because medical staff bring direct knowledge of clinical realities, operational challenges, patient care implications, and recruitment needs.

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

– Physician, FEMS Post-Claim Survey

Survey responses similarly show that FE creates pathways for medical staff voice to be organized and brought forward. Respondents described FE as supporting participation in committees, working groups, HA planning and consultation activities, and physician-led improvement projects. Several comments emphasized that FE funding makes it possible for physicians to take part in non-clinical planning work, contribute to operational discussions, and participate in projects that improve care, workflow, and workplace culture.

Quantitative survey findings support this interpretation. These findings suggest that MSAs are generally seen as representing and communicating member priorities, while also pointing to an opportunity to strengthen how impacts are measured and communicated back to members and partners (see Figure 2 above). Open-ended survey responses also point to opportunities for strengthening the route from voice to action. Respondents suggested clearer processes for MSA engagement with Health Authorities on patient safety and service issues, more transparency about FE project selection and budgets, clearer outcome measures, stronger routes from successful projects to implementation funding, and greater consistency across sites.

Overall, FE is helping medical staff perspectives become more organized, visible, and actionable. However, the degree to which collective voice shapes final decisions varies across contexts. The next phase of the evaluation should examine what helps medical staff voice translate into action, implementation, and sustained impact.

SITE HIGHLIGHT

Building Regional Collective Voice Around Patient Transport and Care Closer to Home: East Kootenay Patient Transport Committee

The East Kootenay Patient Transport Committee brought together physician representatives from all five East Kootenay rural sites, East Kootenay Regional Hospital (EKRH), HA partners, and BC Emergency Health Services (BCEHS) to better understand and address patient transport challenges. The committee focused on building shared knowledge across facilities, improving data-informed discussions, strengthening rural site capacity, and connecting local and regional physician voices to broader policy and planning tables.

Promoting engagement and health system impacts through FE:

- *Provider experience, physician voice, and collaborative decision-making:* The committee created a recurring forum for all five East Kootenay rural sites and EKRH. Four new physicians were recruited to restore representation from each rural site, and HA site leaders sought involvement in the committee.
- *Interprofessional collaboration, information sharing, and system capacity:* Physicians, HA partners, HART, emergency medicine leadership, site leaders, BCEHS, and other regional partners participated. BCEHS was present at every meeting, supporting coordinated discussion of transport demands, constraints, and potential solutions.
- *Patient experience, access, and care coordination:* The committee focused on new transfer coding, supported implementation of transfer codes, tracked transports requiring nurses or physicians to accompany patients, and informed feedback to the Patient Transfer Network.
- *Equity, geographic access, and rural resource flows:* The committee gathered transportation issues from rural communities, improved sharing across MSAs, and brought rural access concerns into regional planning, supporting more equitable attention to transport challenges and rural site capacity.
- *Population health, health service use, and practice efficiency:* The committee identified the need for ultrasound access in Invermere and supported a business case for ultrasound at IDH. The service is now fully functional five days a week. The committee also helped build a collaborative regional CT business case that received full HA approval, while exploring strategies to reduce unnecessary transport, maintain appropriate care closer to home, and improve regional use of services and resources.

Enabling conditions across outcomes 1 to 3: What helps FE-supported engagement move toward impact?

FE-supported engagement was more likely to move from connection and discussion toward action when several enabling conditions were present. These conditions do not guarantee impact, but they help explain why some activities were better positioned to influence planning, implementation, provider experience, patient care, access, or system improvement.

Key enabling conditions included:

- **Recurring structures and protected time:** FE-supported meetings, working groups, regional tables, and project activities provided regular opportunities for medical staff to participate in non-clinical improvement work. Compensation and protected time helped legitimize this participation and made

it more feasible for medical staff to contribute to planning, relationship-building, and quality improvement.

- **Active local and regional leadership:** Engagement was stronger where MSA, Physician Society, site, and regional leaders helped organize priorities, bring people together, maintain momentum, and connect medical staff perspectives to relevant decision-making spaces.
- **Consistent HA participation:** FE-supported engagement was more likely to move toward action when HA partners participated regularly, had clear roles, understood medical staff priorities, and had sufficient authority or capacity to respond.
- **Inclusive participation across roles, departments, and sites:** Activities that involved multiple specialties, departments, professions, or sites helped reduce silos, broaden understanding of shared challenges, and create stronger collective voice. This was especially important for regional and rural issues that could not be addressed by a single site alone.
- **Clear routes from discussion to action:** Engagement was stronger when there were practical mechanisms for moving issues forward, such as project review processes, escalation pathways, documented priorities, terms of reference, implementation plans, data collection, or follow-up with HA partners.
- **Familiarity with FE and involvement in MSA work:** Survey findings suggest that respondents who were more familiar with FE and more involved in the work of their MSA tended to report more positive experiences, including higher psychological safety and communication scores (see box on next page). This indicates that awareness and participation are not just outputs of engagement but may also be enabling conditions that strengthen the quality of engagement itself.

These enabling conditions also help interpret the unevenness identified across the findings. Where recurring structures, leadership, HA participation, role clarity, and follow-through were present, FE-supported engagement was more likely to contribute to concrete planning, collaboration, and improvement work. Where these conditions were weaker, engagement was more likely to remain at the level of consultation, relationship-building, or issue identification without clear evidence of action.

Greater familiarity with FE and involvement in MSA work are associated with significantly more communication, psychological safety, and personal accomplishment

The survey findings point to familiarity with FE and involvement in MSA work as important enabling conditions. Respondents who reported greater familiarity with FE and higher involvement in the work of their MSA reported higher psychological safety and communication scores. Respondents who reported higher involvement in MSA work also reported a higher sense of personal accomplishment.

These findings are important because they suggest that FE engagement may be self-reinforcing: as medical staff become more familiar with FE and more involved in MSA work, they report stronger communication, greater psychological safety, and a greater sense of accomplishment. At the same time, the findings point to an opportunity to broaden awareness and participation among less-engaged groups so that more medical staff can benefit from FE-supported structures and opportunities.



Note. Bars show mean scale scores by respondents' familiarity with FE and their level of involvement in the work of their MSA. Scores are shown on a five-point scale ranging from -2 to +2, where -2 = strongly disagree, 0 = neither agree nor disagree, and +2 = strongly agree. Means represent aggregate scale scores across multiple survey items. Overall sample sizes were $N = 1,087$ for psychological safety and $N = 1,112$ for communication. Differences by familiarity were statistically significant for both psychological safety, Welch's $F(4, 271.65) = 36.78$, $p < .001$, $\eta^2 = .11$, and communication, Welch's $F(4, 287.64) = 48.96$, $p < .001$, $\eta^2 = .14$. Differences by involvement were statistically significant for both psychological safety, Welch's $F(4, 500.12) = 78.20$, $p < .001$, $\eta^2 = .22$, and communication, Welch's $F(4, 511.55) = 110.80$, $p < .001$, $\eta^2 = .24$. Higher scores indicate greater psychological safety and more positive communication.

EVALUATION FINDINGS OF FE BASED ON THE JCC QUINTUPLE AIM FRAMEWORK

Evaluation take-away

FE-supported structures and activities contribute to the JCC Quintuple Aim most clearly by strengthening provider experience and by creating the relationships, communication channels, and improvement structures that support better care. Evidence related to patient experience, population health, cost and resource use, equity, and access to quality care is also present, although the strength and consistency of evidence vary across domains.

Across the sources reviewed, FE-supported structures and activities contribute to the JCC Quintuple Aim through both direct activity-level changes and enabling conditions for future improvement. The clearest and most consistent evidence relates to provider experience, including connection, morale, psychological safety, communication, and participation in meaningful non-clinical work. Evidence related to patient experience, access, population health, cost and resource use, and equity is also present but varies in strength because these impacts are often activity-specific, indirect, longer-term, or not consistently measured across sites.

The same engagement structures that support connection and collective voice also provide the pathway through which FE can influence the Quintuple Aim

For this reason, the findings below distinguish between demonstrated outcomes, activity-specific examples, emerging contributions, and enabling conditions. This distinction is important because many FE-supported activities are designed to create the relationships, structures, and shared priorities that allow improvement work to happen, even when downstream effects on patient outcomes, population health, equity, or cost are not yet directly measurable.

Provider experience

Provider experience is the strongest and most consistently demonstrated area of FE contribution across the interim evidence. FE-supported activities contribute to provider experience by creating opportunities for medical staff to connect, participate in non-clinical improvement work, feel heard, and build relationships across departments, sites, and roles. The evidence points to several pathways of contribution:

- **Connection and belonging:** FE-supported formal and informal engagement activities reduce isolation, strengthen collegiality, and create a stronger sense of community within facilities.

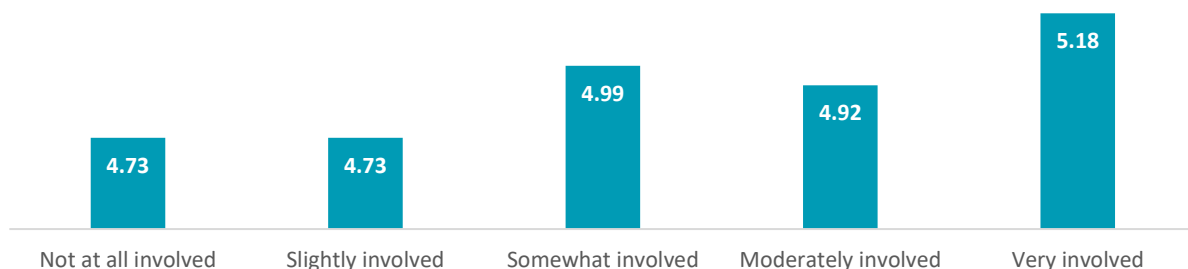
- **Recognition and protected time:** FE funding helped legitimize and compensate medical staff participation in planning, quality improvement, governance, recruitment, retention, and other work that often occurs outside regular clinical duties.
- **Orientation, recruitment, and retention:** Some activities supported new physicians and locums, strengthened site relationships, and helped create a more welcoming and sustainable work environment.
- **Confidence and professional accomplishment:** Shared learning, simulation, CME, leadership activities, and quality improvement work helped medical staff build skills, contribute to solutions, and experience a stronger sense of meaningful contribution.

Survey findings reinforce provider experience as a strong area of FE contribution

Survey responses reinforce provider experience as one of the clearest areas of FE impact. Respondents identified formal and informal activities that helped them feel valued, reduced isolation, improved communication, and strengthened the sense of community within the hospital. Others linked provider experience to retention, noting that opportunities for connection, wellness, and peer support can help sustain physicians in difficult work environments.

Respondents generally reported positive experiences related to psychological safety, communication, and personal accomplishment. Respondents who reported higher involvement in the work of their MSA also reported a higher sense of personal accomplishment (see Figure 5) while those with greater familiarity with FE and higher involvement in MSA work reported higher psychological safety and communication scores as described previously. These findings suggest that FE-supported engagement is associated not only with more opportunities to participate, but also with stronger experiences of communication, safety, and meaningful contribution among those who are more familiar with and involved in FE.

Figure 5 **Personal accomplishment higher among respondents more involved in MSA work**



Note. Bars show mean personal accomplishment scale scores by respondents' level of involvement in the work of their MSA. Scores are shown on a 0 to 6 frequency scale where higher scores indicate more frequent experiences of personal accomplishment. Means represent aggregate scale scores across multiple survey items. The overall sample size was $N = 1,105$. Differences by involvement were statistically significant, Welch's $F(4, 476.86) = 6.40$, $p < .001$, $\eta^2 = .02$.

Patient experience

FE-supported activities contribute to patient experience and access to quality care in both direct and indirect ways. The clearest direct examples are activities that created or improved care pathways, referral processes, patient safety processes, patient transfers, care coordination, and service availability. In other cases, FE contributed more indirectly by strengthening the provider relationships, communication channels, workforce capacity, and operational coordination needed to support patient care. Across the interim evidence, FE supported patient experience and access through several main pathways:

- **Care pathways and referral processes:** Some activities developed or improved referral pathways, clinical workflows, and coordination processes for specific patient groups. These activities helped clarify roles, improve communication, and connect patients to appropriate services.
- **Care coordination across providers and settings:** FE-supported engagement helped bring together physicians, HA partners, nurses, pharmacists, outreach services, community providers, and other partners to address gaps between hospital, community, and regional services.
- **Patient safety and continuity of care:** Some activities focused on documentation, clinical communication, patient transfer processes, service coverage, and crisis response planning, with the goal of reducing gaps in care and supporting continuity for patients.
- **Rural and regional access:** Regional activities helped identify access barriers that extend beyond a single site, such as patient transport challenges, transfer processes, and the ability to provide appropriate care closer to home (see East Kootenay Patient Transport Committee Spotlight).
- **Workforce and service capacity:** Recruitment, orientation, hospitalist program development, and service coverage activities contributed indirectly to access by supporting the availability and sustainability of medical services.

These findings suggest that FE contributes to patient experience and access most often by helping medical staff and HA partners identify practical barriers, build shared solutions, and coordinate across roles, departments, sites, and services. However, patient experience and access outcomes were not measured consistently across activities. In many cases, the evidence shows strong mechanisms and activity-specific examples, while broader or longer-term patient outcomes remain an area for further measurement.

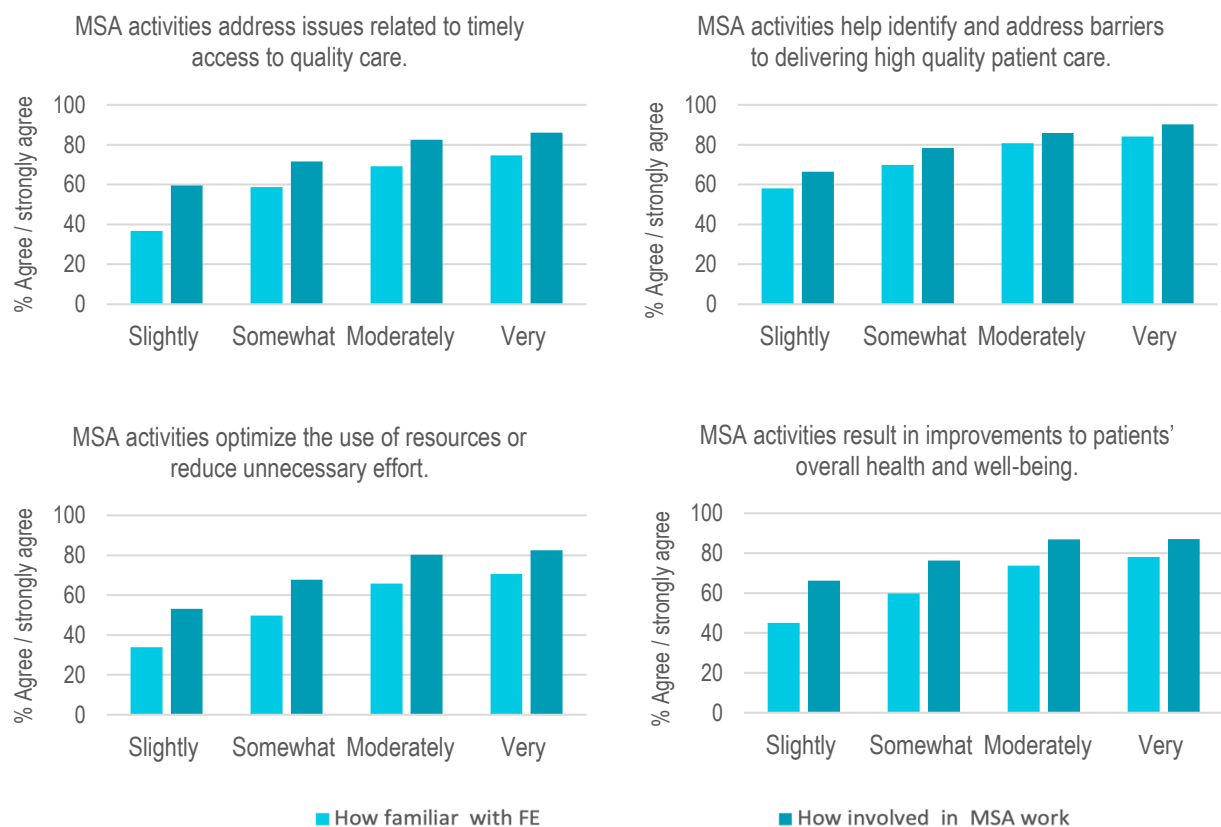
Survey findings support FE's contribution to access and high-quality care

Qualitative survey responses also provide examples of FE-supported activities linked to patient care, quality, and access. Respondents identified clinical texting, acute radiculopathy pathways, multidisciplinary rounds, tumour boards, central intake projects, hospitalist and general surgery collaboration, patient care advocacy, simulations, quality improvement projects, and physician-led

process improvements as meaningful activities. Several responses described FE-supported projects as improving care quality, supporting team-based care, addressing workflow challenges, and improving collaboration between specialists, family physicians, and other providers. These findings support the interpretation that FE contributes to access and quality most often through the practical mechanisms of collaboration, communication, pathway development, and physician-led improvement work.

Quantitative findings provide additional support for this interpretation. Most respondents agreed that they had observed MSA activities that help identify and address barriers to delivering high-quality patient care, address issues related to timely access to quality care, and result in improvements to patients' overall health and well-being through improved access to care. Agreement increased with familiarity with FE and involvement in MSA work, indicating that more familiar and involved respondents were more likely to report positive perceptions of MSA contributions to access, care quality, and patient health (see Figure 6).

Figure 6 Perceived MSA activities' impacts on access, care quality, resource use, and population health increased with familiarity and involvement



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

Population health

Population health impacts are more difficult to assess at this interim stage because they are often longer-term and mediated through improvements in access, equity, care coordination, prevention, service continuity, and care quality. Most FE-supported activities were not designed or measured in ways that would allow direct assessment of population-level outcomes. However, the interim evidence identifies several plausible pathways through which FE-supported engagement may contribute to population health over time. These include improving access to care for specific patient groups, strengthening rural and regional service coordination, supporting continuity of care, addressing barriers faced by socially vulnerable populations, improving patient transfer processes, and developing shared approaches to clinical care.

Some activity-specific examples also included more concrete patient-level or health-related indicators. These included reduced daily morphine milligram equivalents, low complication rates, reduced length of stay, improved referral pathways, more timely patient transfers, and coordinated responses to staffing pressures that helped avoid disruption to patient care or adverse patient outcomes. These examples suggest that FE-supported engagement can contribute to conditions associated with improved health outcomes, although they do not yet provide consistent evidence of population-level change.

Activities related to opioid agonist therapy, liver and addiction care coordination, rural patient transport, care closer to home, cultural safety, clinical pathway development, and service continuity all point to ways FE-supported engagement can contribute to broader health outcomes. At this stage, these examples are best interpreted as emerging pathways to population health impact, supported by selected activity-level indicators, rather than direct evidence of population-level change.

Cost and resource use

Cost and resource-use impacts appeared across administrative data, but the strength of evidence varied. Some examples described reduced costs, reduced duplication, improved efficiency, reduced unnecessary effort, better use of resources, under-budget delivery, reduced length of stay, reduced pharmacy costs, or improved patient flow. Other examples framed cost-related impacts as expected or indirect, such as reducing avoidable transfers, improving communication, streamlining recruitment, reducing administrative burden, or supporting care closer to home.

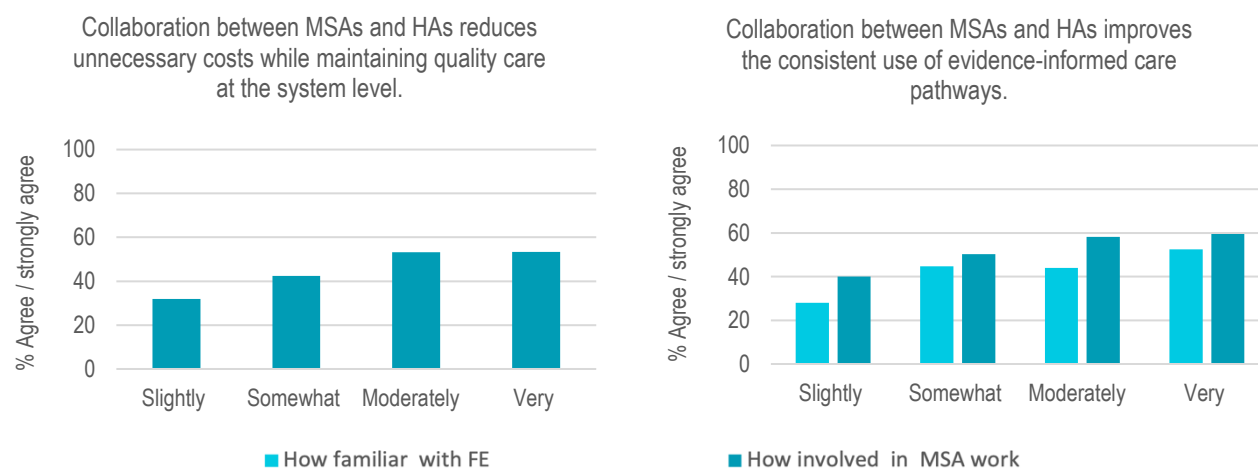
The strongest cost-related examples were activity-specific. For example, some activities reported reduced length of stay, reduced costs per patient, reduced Post Anaesthesia Care Unit (PACU) use, or more efficient use of anesthesiology resources. One block room activity described more efficient care through shorter or non-existent PACU visits while another activity reported that anesthesiologists could serve multiple patients in a block room rather than providing one-to-one service, contributing to shorter surgical wait lists and decreased hospital costs. AR examples described improved emergency department workflow, hospitalist model review, coordinated staffing responses, and recruitment and retention infrastructure as ways to improve efficiency or reduce unnecessary strain. Other examples linked regional knowledge

sharing and collaboration to avoiding duplication, improving transfers, discussing operational priorities, and sharing strategies related to per capita cost.

Survey findings suggest that cost and resource-use impacts are less consistently measured than collaboration or provider experience impacts. Just over half of respondents agreed that they had observed MSA activities optimizing the use of resources or reducing unnecessary effort while fewer than half agreed that current collaboration between MSAs and HAs reduces unnecessary costs while maintaining quality care at the system level. Similarly, fewer than half agreed that current MSA and HA collaboration improves the consistent use of evidence-informed care pathways. However, as familiarity with FE and/or involvement with their MSA increased, so too did perceptions of collaboration between MSAs and HAs as facilitators of lower costs and use of evidence-informed pathways (see Figure 7). These findings support the interpretation that cost and resource-use outcomes are emerging and activity-specific rather than consistently demonstrated across FE.

Overall, our findings suggests that FE can support cost and resource-use improvements when engagement leads to more efficient workflows, better coordination, or reduced duplication, further supported by the survey findings. However, cost outcomes were not measured consistently across activities. At this interim stage, it would be most accurate to describe cost-related impacts as emerging and example-specific rather than as a demonstrated initiative-wide outcome.

Figure 7 MSA–HA collaboration was associated with greater perceived system-level cost and care pathway impacts as familiarity and involvement increased



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

SITE HIGHLIGHT

Improving OAT Access and Continuity Across Hospital and Community Settings: South Okanagan General Hospital OAT Pathway

The South Okanagan General Hospital Emergency Room (ER) and Inpatient Opioid Agonist Therapy (OAT) Pathway addressed a gap in care coordination for patients receiving or requiring OAT who present to the emergency department or are admitted as inpatients. Before the activity, there was no formal referral or consultation pathway linking acute care settings with local OAT services in Oliver and Osoyoos, contributing to fragmented transitions and inconsistent follow-up.

Promoting engagement and health system impacts through FE:

- *Provider experience, interprofessional collaboration, and system capacity:* The work strengthened relationships across physicians, the Interior Health Clinical Practice Educator, Interior Health Nurse Prescribers, ER and inpatient nursing staff, community pharmacists, and the Martin Street Outreach Clinic and improved provider engagement across hospital and community care settings.
- *Patient experience, access, and care coordination:* The project developed a structured ER referral pathway for OAT consultations, created supporting resources, and distributed information to ER physicians and nursing staff. It also supported inpatient OAT consult planning, including Meditech consult order entry, nursing education, and ER resource support. Early results showed nine ER-initiated referrals and one inpatient referral.
- *Continuity across transitions and sustainability:* The team met with IHA Nurse Prescribers to establish coverage for ER OAT referrals during physician absences, with nurse prescribers providing backup support when the OAT physician is unavailable. The project improved continuity of OAT care across hospital and community settings.
- *Equity and geographic access:* The activity addressed local service gaps after a provider departure and reduced care availability at Martin Street Outreach Centre in Penticton. Transportation barriers to Penticton further limited access, prompting development of a local Oliver clinic using an “Every door is the right door” model.
- *Population health and substance use:* The pathway responded to the toxic drug supply crisis by improving local access to OAT.

Patient and provider equity

FE-supported activities created opportunities to advance equity for both patients and providers, although equity impacts were less consistently measured than provider experience, engagement, and patient experience.

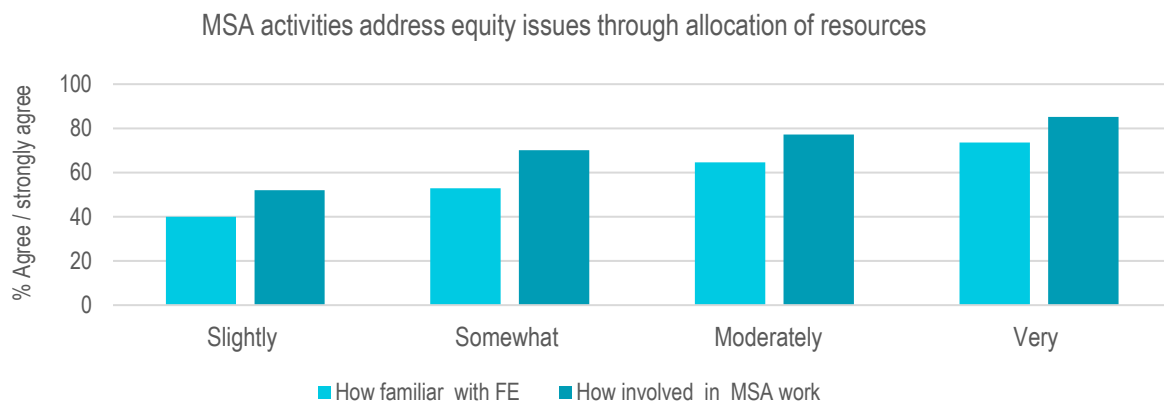
- **Patient equity examples:** Included activities focused on rural and remote access, care closer to home, Indigenous patient barriers, cultural safety and anti-racism, substance use and addiction care, child and youth mental health, socially vulnerable populations, and improved coordination across hospital, community, and regional services.

- Provider equity examples:** Included efforts to broaden participation in engagement activities, reduce barriers to involvement, create hybrid or lower-barrier engagement opportunities, support rural medical staff and rural recruitment, strengthen inclusion across departments or sites, and ensure that diverse medical staff voices were included in planning and decision-making. Some regional examples also focused on addressing bias and inequities, increasing confidence to lead change, and improving equal access to resources across sites.

The survey findings provide additional support for equity-related contributions while also reinforcing that equity impacts are less consistently demonstrated than collaboration or provider experience. A majority of respondents agreed that they had observed MSA activities addressing equity issues through the allocation of resources, such as rural access, cultural safety, or inclusive participation, and these increased significantly with familiarity and involvement (see Figure 8). However, agreement on this item was lower than agreement on collaboration across physician groups or departments, suggesting that equity is present in FE-supported work but may be less visible, less consistently measured, or less consistently experienced across respondents.

At this interim stage, equity was often described as an intended outcome, emerging contribution, or enabling condition rather than as a consistently measured outcome. Additional efforts are needed to measure direct and indirect equity improvements for both providers and patients. This could include tracking who participates in FE-supported engagement, which groups benefit from activities, whether activities reduce barriers to care or participation, and whether improvements are experienced consistently across sites, regions, provider groups, and patient populations.

Figure 8 Perceived equity impacts increased with familiarity and involvement



Note. Chi-square tests of independence were significant at $p < .001$, indicating that agreement differed significantly by respondents' familiarity with FE and level of involvement in MSA work. Higher familiarity and involvement were associated with higher agreement.

WHAT OPPORTUNITIES EXIST FOR FE GOING FORWARD?

Taken together, the interim findings point to both early strengths and practical opportunities for SSC to consider to strengthen FE over the remainder of the evaluation period—primarily related to strengthening the conditions that help engagement translate into meaningful action. Further details are provided in Table 2.

Table 2 Opportunities for the future

Categories	Opportunities for...
Awareness & participation	▪ Increase awareness of FE among less-engaged groups, including newer physicians, frontline physicians who do not hold formal leadership roles, community providers connected to facility-based care, rural and remote providers, and non-physician medical staff where eligible ▪ Continue supporting low-barrier relationship-building opportunities, including recurring meetings, lunches, commensality groups, wellness activities, and informal forums that help build trust before operational or clinical issues need to be addressed ▪ Strengthen HA participation in FE-supported engagement forums, particularly by encouraging consistent attendance from partners with the authority and role clarity needed to respond to medical staff priorities
Administration & operations	▪ Clarify roles and expectations across MSAs, program/project managers, Engagement Partners, and HA partners so that operational support strengthens, rather than replaces, physician-led priority-setting and decision-making ▪ Reduce administrative burden where possible, including through simpler claim processes, more user-friendly FEMS systems, clearer post-claim requirements, and streamlined funding or reporting processes
Outcomes tracking & communication	▪ Build more consistent outcome tracking for selected FE-supported activities, especially where activities aim to affect access, patient experience, cost/resource use, equity, recruitment and retention, or provider experience ▪ Improve feedback loops so medical staff can see how their input has influenced planning, decisions, project design, or operational changes, even when the outcome is still pending or when a proposed change cannot move forward

Categories	Opportunities for...
Moving beyond engagement	▪ Clarify pathways from engagement to action, including how issues raised through MSAs, regional tables, and FE-supported projects are documented, escalated, followed up, and, where appropriate, moved into implementation ▪ Identify promising activities or projects that may be ready for spread, sustainability planning, or transition to HA or other system-level support if they have demonstrated value beyond initial engagement

These opportunities will be explored further through the next phase of the evaluation. In particular, case studies and additional administrative and financial data review can help clarify which conditions make FE-supported engagement more likely to influence planning, implementation, access, equity, provider experience, and other JCC Quintuple Aim-related outcomes.

WHAT ARE THE NEXT STEPS IN THE EVALUATION?

As per the evaluation plan developed collaboratively by the SRDC and FE teams early in the evaluation, next steps in the evaluation include the following:

1. **Thematic case studies (Summer/Fall 2026):** Following finalization of the interim report, SRDC will work with the FE team to determine priority themes for deeper exploration through a series of three to four case studies. Each case study will focus on a specific theme, with interviews serving as the core data source to build out each theme. The interim findings will inform the case studies in several ways:

Interim findings will guide case study selection. Case study themes will focus on areas where the emerging findings are strong enough to warrant deeper exploration but where more descriptive evidence is needed to understand mechanisms, context, and conditions for impact.

Case study themes will be prioritized to align with the main patterns identified to date and may include, for example:

- How recurring engagement structures build connection, trust, and collective voice;
- How FE-supported engagement strengthens or is limited by HA participation;
- How physician voice moves from individual concerns to organized input and decision-making influence;
- How FE contributes to provider experience, wellness, recruitment, and retention;
- How FE-supported activities contribute to access, patient care, equity, or resource stewardship through specific projects or care pathways; and
- What supports are needed to move FE-funded activities from ideas or pilots into implementation and sustainability.

Differences in experiences by level of FE familiarity and involvement reflected in the quantitative survey findings, as well as ensuring representation across role, region, and demographic characteristics will be used to shape interview sampling and case study questions.

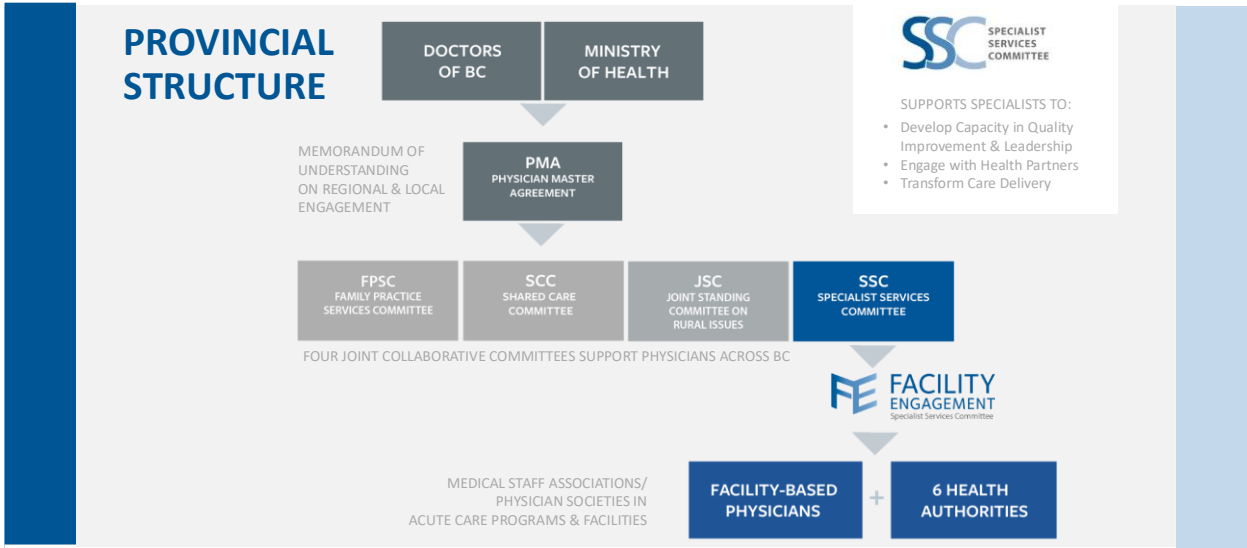
Case study interview questions will explore both successes and conditions for impact. Topics may include, for example, HA engagement, role clarity, project management support, funding and reporting processes, administrative burden, implementation follow-through, and how medical staff know whether their input has influenced decisions.

Across case studies, diverse perspectives will be sought, such as MSA leaders, frontline physicians, newer physicians, HA partners, program/project managers, Engagement Partners, and, where relevant, non-physician medical staff.

Case studies will aim to examine variation across contexts, including rural and urban settings, smaller and larger MSAs, regional tables, cross-site initiatives, and activities with different levels of HA participation.

- 2. Administrative and financial program data review (Fall 2026):** SRDC will conduct a second round of administrative and financial program data review to update the activity landscape, explore patterns in FE-supported activity types, and identify whether additional data are available on costs, resource use, participation, project completion, sustainability, or spread.
- 3. Reflection session (approximately January 2027):** A reflection session will be conducted prior to final reporting to provide a chance for the FE team to reflect on evaluation findings gathered and share their own FE experiences and insights.
- 4. Final report (February/March 2027):** In the final evaluation report, SRDC will triangulate evidence across administrative data, survey findings, open-ended responses, case studies, and the FE team reflection session to assess outcomes achievement, identify lessons learned, and provide recommendations/opportunities for strengthening FE.

APPENDIX A: PROVINCIAL STRUCTURE⁸



SSC FACILITY ENGAGEMENT

⁸ Figure from the Facility Engagement 101 Master Slide Deck (internal document).

APPENDIX B: WHAT DO FE-SUPPORTED ACTIVITIES LOOK LIKE?

The FEMS activity descriptions show that FE-supported activities were broad in scope, ranging from regular MSA governance and engagement infrastructure to targeted projects addressing clinical workflows, physician wellness, recruitment and retention, quality improvement, patient flow, cultural safety, and regional collaboration. These activities tended to fall into four main categories:

- **Creating conditions for engagement:** Some activities—such as MSA executive meetings, working groups, annual general meetings, strategic planning sessions, project management, communication supports, and physician sessional time for participation in local, regional, or HA-level discussions—focused primarily on creating the conditions for engagement. These activities provided the operational foundation for MSAs to organize physician input, support project development, communicate priorities, and sustain engagement over time.
- **Relationship-building and provider experience activities:** Examples included physician wellness events, peer support training, mentorship and orientation for new physicians or locums, women in medicine networks, social gatherings, leadership retreats, as well as informal opportunities for physicians to connect with one another and with HA partners. Several activity descriptions framed these activities as ways to reduce isolation, support retention, build collegiality, improve morale, and create a more supportive work environment.
- **Shared learning, collaborative decision-making, and quality improvement opportunities activities:** These activities included simulation training for high-acuity low-opportunity events, CME and Continuing Professional Development (CPD) programming, journal clubs, educational rounds, interdisciplinary seminars, emergency preparedness training, physician education related to Electronic Health Records (EHRs), and clinical training involving physicians, nurses, respiratory therapists, pharmacists, students, residents, and other providers. These activities often linked engagement to practical goals such as strengthening communication, improving role clarity, supporting safe practice, and building shared approaches to care.
- **Activities with more direct links to care delivery, access, resource use, and system improvement:** Examples included work on after-hours operating room use, same-day discharge pathways, rapid access clinics, patient transfers, hospitalist models, emergency department processes, direct messaging workflows, EHR optimization, recruitment strategies, local computed tomography (CT) scanner planning, green inhaler prescribing, cultural safety and antiracism initiatives, and clinical pathways for specific patient populations. These activities suggest that FE engagement is not limited to relationship-building but also creates a structure through which medical staff and HA partners can identify practical problems, develop solutions, and begin testing changes that may improve provider experience, patient experience, access to care, equity, and resource stewardship.

APPENDIX C: FE SURVEY COMMUNICATION MATERIALS AND QUESTIONNAIRE

FE SURVEY COMMUNICATION MATERIALS (EMAIL INVITATION AND REMINDERS)

Note: “Dr” to be added to the greeting for the invitation and reminder emails for the following only (as per “Field” column of contact list):

- Dentist
- Family practice
- Podiatrist
- Specialist physician
- Clinical psychologist
- Pharmacist

Invitation (February 25, 2026)

Subject Line: The Specialist Services Committee Requests Your Valuable Input in the Evaluation of the Facility Engagement Initiative

Dear Dr [First and last name],

The Specialist Services Committee is conducting an evaluation of the Facility Engagement Initiative (FEI). As part of this evaluation, we invite you to participate in a **10-minute survey to share your experiences of Medical Staff Association (MSA)/Physician Engagement Society member engagement.** Findings will support ongoing learning and identification of opportunities for improvement.

This survey:

- Is being conducted by [SRDC](#), an independent non-profit research and evaluation organization
- Is voluntary and anonymous
- Is separate from the Doctors of BC Health Authority Engagement Survey that took place in the fall
- Is being administered through the Qualtrics online survey platform (all data gathered through this survey will be housed in Canada)

To access the survey, please click the individualized link below. **DO NOT SHARE** this link. You can re-click your individualized link at any point before March 18th to view and/or revise your confidential responses (prior to submitting them).

- Your INDIVIDUALIZED SURVEY LINK is: **INSERT PERSONALIZED LINK**

If you know of others who might want to complete the survey, you can forward them the following general link: https://srdc.ca1.qualtrics.com/jfe/form/SV_5o7jTIJAoZJTY4S

If you have any questions regarding the survey, please contact Jacey Payne (Senior Research Associate, SRDC): jpayne@srdc.org. For questions related to Facility Engagement, please contact engagement@doctorsofbc.ca.

We appreciate your time and look forward to hearing from you.

Best regards,
[SRDC contact]



Reminder 1 (March 5, 2026)

Subject Line: Reminder: The Specialist Services Committee Requests Your Valuable Input in the Evaluation of the Facility Engagement Initiative

Dear Dr [First and last name],

We would greatly appreciate your participation in this **10-minute survey** as part of the **evaluation of the Facility Engagement Initiative (FEI)** to ensure that views and experiences from your site/organization are represented. This survey is conducted by [SRDC](#), an independent non-profit research and evaluation organization.

To access the survey, please click the individualized link below. DO NOT SHARE this link. You can re-click your individualized link at any point before March 18th to view and/or revise your confidential responses (prior to submitting them). If you have already begun the survey, thank you for taking the time to start it—we would greatly appreciate it if you could please return to complete and submit your responses.

- **Your INDIVIDUALIZED SURVEY LINK is:** [INSERT PERSONALIZED LINK](#)

If you know of others who might want to complete the survey, you can forward them the following general link: https://srdc.ca1.qualtrics.com/jfe/form/SV_5o7jTIJAoZJTY4S

Your input will help us better understand the impact of the Facility Engagement initiative and your experiences with it. It only takes about 10 minutes to complete.

If you have any questions regarding the survey, please contact Jacey Payne (Senior Research Associate, SRDC): jpayne@srdc.org. For questions related to Facility Engagement, please contact engagement@doctorsofbc.ca.

We appreciate your time and look forward to hearing from you.

Best regards,
[SRDC contact]



Reminder 2 (March 12, 2026)

Subject Line: Important reminder: Facility Engagement Initiative evaluation

Dear Dr [First and last name],

The Specialist Services Committee would greatly appreciate your participation in this **10-minute survey** as part of the **evaluation of the Facility Engagement Initiative (FEI)** to ensure that views and experiences from your site/organization are represented. This survey is conducted by [SRDC](#), an independent non-profit research and evaluation organization.

To access the survey, please click the individualized link below. DO NOT SHARE this link. You can re-click your individualized link at any point before March 18th to view and/or revise your confidential responses (prior to submitting them). If you have already begun the survey, thank you for taking the time to start it—we would greatly appreciate it if you could please return to complete and submit your responses.

- **Your INDIVIDUALIZED SURVEY LINK is:** [INSERT PERSONALIZED LINK](#)

If you know of others who might want to complete the survey, you can forward them the following general link: https://srdc.ca1.qualtrics.com/jfe/form/SV_507jTIJAoZJTY4S

Please note that a minimum of five responses is required to access site-level survey data. We encourage you and your colleagues to participate in the survey to ensure that this threshold is met. Your insights will be invaluable as we continue to strengthen FE!

Your input will help us better understand the impact of the Facility Engagement initiative and your experiences with it. It only takes about 10 minutes to complete.

If you have any questions regarding the survey, please contact Jacey Payne (Senior Research Associate, SRDC): jpayne@srdc.org. For questions related to Facility Engagement, please contact engagement@doctorsofbc.ca.

We appreciate your time and look forward to hearing from you.

Best regards,
[SRDC contact]



Final reminder (March 17, 2026⁹)

Subject Line: Important final reminder: Facility Engagement Initiative evaluation

Dear Dr [First and last name],

The Specialist Services Committee requests your valuable input in the evaluation of the Facility Engagement Initiative!

Our FE provincial evaluation survey will be closing tomorrow.

If you haven't had a chance to complete our quick, 10-minute survey yet, please share your feedback here, using this individualized survey link: INSERT PERSONALIZED LINK. If you have already begun the survey, thank you for taking the time to start it—we would greatly appreciate it if you could please return to complete and submit your responses.

If you know of others who might want to complete the survey, you can forward them the following general link: https://srdc.ca1.qualtrics.com/jfe/form/SV_5o7jTIJAoZJTY4S

Please note that a minimum of five responses is required to access site-level survey data. We encourage you and your colleagues to participate in the survey to ensure that this threshold is met. Your insights will be invaluable as we continue to strengthen FE!

Best regards,
[SRDC contact]



⁹ Although March 18, 2026 was the survey end date shared with invitees, the survey was left open online until the morning of March 23, 2026 to allow extra time for response.

FE SURVEY QUESTIONNAIRE

FE Medical Staff and Health Authority Partner Survey

[\[Survey Landing Page\]](#)

Thank you for taking the time to complete this survey. The goal of this survey is to understand your experiences participating in the Facility Engagement ([FE](#)) Initiative. Your responses will support the independent evaluation of FE conducted by the Social Research and Demonstration Corporation ([SRDC](#)), an independent non-profit research and evaluation organization.

Your participation is voluntary, and your responses are anonymous. No identifying information will be included in any reports or presentations, and we will make every effort to protect respondent anonymity. Please note, however, that the FE team must access the raw survey data for reporting purposes. If you choose to include identifying details in open-ended responses, your identity may be discernible. Any such information will be handled with strict confidentiality and will not be shared beyond the small team responsible for reporting.

Definitions. For the purposes of this survey, Medical Staff Association (**MSA**) refers to the formal body representing medical staff at a facility, and also includes Physician Engagement Societies. MSAs may carry out both FE-supported engagement activities and other activities related to governance, administration, or routine MSA business. When survey questions refer to involvement, participation, or activities, respondents should consider *FE-supported engagement activities only*.

This survey will take approximately 10 minutes to complete. *Please complete the survey by **March 18 2026**.*

If you have questions about the survey or the evaluation, please contact Jacey Payne SRDC at: jpayne@srdc.org

[Page Break]

Demographics and Background

The questions in this section ask about your role, where you work, and your familiarity and involvement with FE and your MSA.

1a. At which health authority do you primarily work? If you work at multiple, please select the one at which you spend the *most* time.

- ☐ First Nations Health Authority
- ☐ Fraser Health
- ☐ Interior Health
- ☐ Northern Health
- ☐ Provincial Health Services Authority
- ☐ Providence Health Care
- ☐ Island Health
- ☐ Vancouver Coastal Health

1b. [\[logic – if respondent selects Interior Health Authority in 1a\]](#) Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ 100 Mile District General Hospital
- ☐ Arrow Lakes Hospital
- ☐ Boundary District Hospital
- ☐ Cariboo Memorial Hospital
- ☐ Creston Valley Hospital & Health Centre
- ☐ Dr. Helmcken Memorial Hospital
- ☐ East Kootenay Regional Hospital
- ☐ Elk Valley Hospital
- ☐ Golden and District Hospital
- ☐ Invermere and District Hospital
- ☐ Kelowna General Hospital
- ☐ Kootenay Boundary Regional Hospital
- ☐ Kootenay Lake Hospital
- ☐ Lillooet Hospital & Health Centre
- ☐ Nicola Valley Hospital & Health Centre
- ☐ Penticton Regional Hospital
- ☐ Princeton General Hospital
- ☐ Queen Victoria Hospital
- ☐ Royal Inland Hospital
- ☐ Shuswap Lake General Hospital
- ☐ South Okanagan General Hospital
- ☐ Vernon Jubilee Hospital
- ☐ Not applicable as I work at a broader health authority level

[\[logic – if respondent selects Fraser Health Authority in 1a\]](#) Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ Abbotsford Regional Hospital and Cancer Centre
- ☐ Burnaby Hospital
- ☐ Chilliwack General Hospital
- ☐ Delta Hospital
- ☐ Eagle Ridge Hospital
- ☐ Fraser Canyon Hospital
- ☐ Langley Memorial Hospital
- ☐ Mission Memorial Hospital
- ☐ Peace Arch Hospital
- ☐ Ridge Meadows Hospital & Health Care Centre
- ☐ Royal Columbian Hospital
- ☐ Surrey Memorial Hospital
- ☐ Not applicable as I work at a broader health authority level

[logic – if respondent selects Island Health Authority in 1a] Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ Cowichan District Hospital
- ☐ Lady Minto Gulf Islands Hospital
- ☐ Nanogis Health Centre
- ☐ Nanaimo Regional General Hospital
- ☐ North Island Hospital Campbell River & District
- ☐ North Island Hospital Comox Valley
- ☐ Port Hardy Hospital
- ☐ Port McNeill Hospital
- ☐ Royal Jubilee Hospital
- ☐ Saanich Peninsula Hospital
- ☐ Tofino General Hospital
- ☐ Victoria General Hospital
- ☐ West Coast General Hospital
- ☐ Not applicable as I work at a broader health authority level

[logic – if respondent selects Northern Health Authority in 1a] Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ Bulkley Valley District Hospital
- ☐ Chetwynd Hospital & Health Centre
- ☐ Dawson Creek and District Hospital
- ☐ Fort Nelson General Hospital
- ☐ Fort St John Hospital & Peace Villa
- ☐ GR Baker Memorial Hospital
- ☐ Haida Gwaii Hospital and Health Centre - Xaayda Gwaay Ngaaysdll Naay
- ☐ Kitimat General Hospital & Health Centre
- ☐ Ksyen Regional Hospital
- ☐ Lakes District Hospital & Health Centre
- ☐ Mackenzie & District Hospital & Health Centre
- ☐ McBride & District Hospital
- ☐ Northern Haida Gwaii Hospital & Health Centre

- ☐ Prince Rupert Regional Hospital
- ☐ St. John Hospital
- ☐ Stuart Lake Hospital
- ☐ University Hospital of Northern British Columbia (UHNBC)
- ☐ Wrinch Memorial Hospital
- ☐ Not applicable as I work at a broader health authority level

[logic – if respondent selects Provincial Health Service Authority in 1a] Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ BC Cancer
- ☐ BC Centre for Disease Control
- ☐ BC Children’s Hospital (including Sunny Hill)
- ☐ BC Women’s Hospital & Health Care Centre
- ☐ BC Adult Mental Health Services
- ☐ BC Corrections
- ☐ Forensic Psychiatric Services
- ☐ Not applicable as I work at a broader health authority level

[logic – if respondent selects Vancouver Coastal Health Authority in 1a] Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ Áuxválásúlas Heiltsuk Hospital (formerly R.W. Large Memorial Hospital)
- ☐ Bella Coola General Hospital
- ☐ GF Strong Rehabilitation Centre
- ☐ Lions Gate Hospital
- ☐ qathet General Hospital
- ☐ Richmond Hospital
- ☐ Sechelt Hospital
- ☐ Squamish General Hospital
- ☐ UBC Hospital (UBCH)
- ☐ Vancouver General Hospital (VGH)
- ☐ Whistler Health Care Centre
- ☐ Not applicable as I work at a broader health authority level

[logic – if respondent selects Providence Health Services Authority in 1a] Please tell us the hospital/facility that you work in or are primarily associated with.

- ☐ St. Paul’s Hospital
- ☐ Mount Saint Joseph Hospital
- ☐ Holy Family Hospital
- ☐ Not applicable as I work at a broader health authority level

[Page Break]

2a. Are you a health care provider?

- ☐ No, I am not a health care provider
- ☐ Yes, I am a family physician
- ☐ Yes, I am a specialist physician

- ☐ Yes, I am a midwife
- ☐ Yes, I am a nurse practitioner
- ☐ Yes, I am a dentist
- ☐ Yes, I am another type of health care provider: [\[Open Text Box\]](#)

2b. [\[logic – if respondent selects No, I am not a health care provider to Q2a\]](#) How would you best describe your position? [\[Open Text Box\]](#)

2c. [\[logic – if respondent selects any “Yes” option to 2a\]](#) How long have you been in practice?

- ☐ 1st year in practice
- ☐ 2 – 5 years
- ☐ 6 – 10 years
- ☐ 11 – 15 years
- ☐ 16 – 20 years
- ☐ 21 – 25 years
- ☐ 26+ years
- ☐ Resident/Fellow
- ☐ I have retired from practicing

[\[Page Break\]](#)

3a. Do you hold a formal health authority leadership role, for which you receive a stipend or salary from the health authority?

- ☐ No
- ☐ Yes, I hold a formal medical leadership role (e.g., department or division head, chief of staff, site medical director, regional medical director, executive medical director, etc.)
- ☐ Yes, I hold a formal operational leadership role (e.g., site director, unit manager, regional director, executive director)

[\[logic – if respondent selects “No” to Q2a AND “No” to Q3a: Redirected to end of survey and receive special message that includes “Based on your responses, no further questions were required, and you have been directed to the end of the survey.”\]](#)

3b. [\[logic – if respondent selects Yes to 3a\]](#) Is your leadership role at a local level, broader health authority level, or both?

- ☐ Local level (e.g., department or division head, chief of staff, site medical director, site director, unit manager)
- ☐ Broader health authority level (e.g., regional medical director, regional director, executive medical director)
- ☐ Both

Please take a moment to review your answers in this section. Once you click Next, changes to this section will no longer be possible.

[\[Page Break\]](#)

4. On a scale from 1 to 5, how familiar are you with the Facility Engagement (FE) Initiative?

The Facility Engagement Initiative was created in 2014 to support medical staff working in facilities across BC to participate in health care planning and solutions. It creates pathways to meaningful collaboration among health authorities and medical staff through MSAs and engagement activities. Through strengthened relationships and communication, it seeks to ultimately improve the delivery of patient care and the clinical work environment.

- ☐ 1. Not at all familiar
- ☐ 2. Slightly familiar
- ☐ 3. Somewhat familiar
- ☐ 4. Moderately familiar
- ☐ 5. Very familiar

5a. On a scale from 1 to 5, how involved are you in the work of the Medical Staff Association (MSA)?

- ☐ 1. Not at all involved
- ☐ 2. Slightly involved
- ☐ 3. Somewhat involved
- ☐ 4. Moderately involved
- ☐ 5. Very involved

5b. [\[Display Logic – if respondent selects Slightly involved, Somewhat involved, Moderately involved, or Very involved to Question 5a\]](#) In what ways are you involved in the work of the MSA? For the purposes of this survey, MSA refers to the formal body representing medical staff at a facility, and also includes Physician Engagement Societies. *Please select all that apply.*

- ☐ Former or current MSA Executive
- ☐ Former or current MSA working group or advisory committee member
- ☐ Former or current Facility Engagement Health Authority Sponsor
- ☐ Lead Facility Engagement funded projects and activities
- ☐ Participated in FE-funded projects and activities (e.g., topic-specific activities or projects, etc.)
- ☐ Attended annual MSA events (e.g., FE Annual Review Process, MSA Annual General Meeting, etc.)
- ☐ Other: [\[Open Text Box\]](#)

[Page Break]

6a. How satisfied are you with your level of involvement in the work of the MSA?

- ☐ I am as involved as I want to be
- ☐ I am interested in being more involved
- ☐ I would like to be less involved
- ☐ I am not interested in being involved

6b. [\[logic – if respondent selects “I am interested in being more involved” to Q6a\]](#) Would any of the following actions by the MSA enable or encourage you to become more involved? Please select all that apply.

- ☐ Raise awareness of participation needs, benefits, or opportunities
- ☐ Create more defined opportunities to get involved (e.g., specific roles/groups)
- ☐ Create or define roles for allied health professionals like midwives or nurse practitioners

- ☐ Hold events during the weekday
- ☐ Hold events outside the weekday (e.g., mornings, evenings)
- ☐ Create more opportunities for informal/social networking (e.g., at dinners/events, in staff lounges) [\[Display Logic: Open Text Box if selected: Please tell us more about what informal/social networking events would enable or encourage you to become more involved.\]](#)
- ☐ Provide more financial incentive for MSA members
- ☐ Focus on different priorities/issues [\[Display Logic: Open Text Box if selected: Please tell us more about what priorities/issues of focus would enable or encourage you to become more involved.\]](#)
- ☐ Address concerns about the MSA (e.g., membership/diversity, leadership) [\[Display Logic: Open Text Box if selected: Please tell us more about what concerns you would like to have addressed in order to enable or encourage you to become more involved.\]](#)
- ☐ Something else would enable or encourage me to become more involved [\[Display Logic: Open Text Box if selected: Please tell us more about what would enable or encourage you to become more involved.\]](#)

[Page Break]

Your Experience with Facility Engagement

The statements in this section describe experiences with MSA activities, including perceived impacts on patient care, the health system, and your work. Please indicate your agreement with the following statements about your MSA.

My MSA...	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Unsure/ Don't Know
7. Has clear measures to assess and communicate the impacts of its activities to members and partners.	☐	☐	☐	☐	☐	☐
8. Represents the priorities and collective interests of its members. [Skipped for anyone who selected “Not at all involved” for 5a.]	☐	☐	☐	☐	☐	☐
9. Provides opportunities to participate in quality or system improvement initiatives.	☐	☐	☐	☐	☐	☐
10. Informs its members about MSA activities, opportunities, and decisions.	☐	☐	☐	☐	☐	☐

[Page Break]

I have observed MSA activities that...	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Unsure/ Don't Know
11. Address issues related to timely access to quality care.	☐	☐	☐	☐	☐	☐
12. Help identify and address barriers to delivering high quality patient care. [Skipped for anyone who selected “Not at all involved” for 5a.]	☐	☐	☐	☐	☐	☐
13. Optimize the use of resources or reduce unnecessary effort.	☐	☐	☐	☐	☐	☐
14. Address equity issues through allocation of resources (e.g. rural access, cultural safety, inclusive participation).	☐	☐	☐	☐	☐	☐
15. Help improve collaboration across different physician groups or departments. [Skipped for anyone who selected “Not at all involved” for 5a.]	☐	☐	☐	☐	☐	☐

16. Result in improvements to patients' overall health and well-being (e.g., better management of physical, mental, or behavioural health needs) through improved access to care.	☐	☐	☐	☐	☐	☐
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[Page Break]

[This section only appears for respondents who selected physician (family and specialist) as their role in 2a.]

When working within my MSA, I feel...	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Unsure/ Don't Know
17. I belong to a collaborative, patient-centered MSA.	☐	☐	☐	☐	☐	☐
18. It is safe to take a risk.	☐	☐	☐	☐	☐	☐
19. No one would deliberately undermine my efforts.	☐	☐	☐	☐	☐	☐
20. Members are able to bring up problems and tough issues.	☐	☐	☐	☐	☐	☐
21. My unique skills and talents are valued and utilized.	☐	☐	☐	☐	☐	☐
22. I can express opinions.	☐	☐	☐	☐	☐	☐
23. My input is sought.	☐	☐	☐	☐	☐	☐

[Page Break]

Your Experience with the Health Authority

The statements in this section describe how your MSA works with the Health Authority, including collaboration, communication, and perceived impacts on patient care, the health system, and your work. Please indicate **your agreement** with the following statements about how your MSA works with the Health Authority.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Unsure/ Don't Know
24. I have seen examples of collaborative decision-making between my MSA and the Health Authority. [Skipped for anyone who selected "Not at all involved" for 5a.]	☐	☐	☐	☐	☐	☐
25. Health Authority leaders communicate the health authority's plans to MSAs in a clear and timely way.	☐	☐	☐	☐	☐	☐

[Skipped for anyone who selected “Not at all involved” for 5a.]						
26. I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients.	☐	☐	☐	☐	☐	☐
27. I understand how to engage with the Health Authority through the MSA.	☐	☐	☐	☐	☐	☐

[Page Break]

Over the past year, current collaboration between MSAs and Health Authorities...	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Unsure/ Don't Know
28. Reduces unnecessary costs while maintaining quality care at the system level. [Skipped for anyone who selected “Not at all involved” for 5a.]	☐	☐	☐	☐	☐	☐
29. Improves the consistent use of clinical guidelines. [Skipped for anyone who selected “Not at all involved” for 5a.]	☐	☐	☐	☐	☐	☐
30. Improves the consistent use of evidence-informed care pathways.	☐	☐	☐	☐	☐	☐

[Page Break]

[This section only appears for respondents who selected physician (family and specialist) as their role in 2a.]

Your Job-Related Feelings in Your MSA

The statements in this section describe job related feelings *as a member of your MSA*. Please indicate how often you have had this feeling.

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day	Unsure/ Don't Know
31. I deal very effectively with the problems of my patients.	☐	☐	☐	☐	☐	☐	☐	☐
32. I feel I'm positively influencing other people's lives through my work.	☐	☐	☐	☐	☐	☐	☐	☐
33. I feel exhilarated after working closely with my patients.	☐	☐	☐	☐	☐	☐	☐	☐

34. I have accomplished many worthwhile things in this job.	☐	☐	☐	☐	☐	☐	☐	☐
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[Page Break]

Final Reflections

The questions in this section invite you to share any additional reflections on your experiences with Facility Engagement, including what has worked well and what could be improved.

35. What MSA activities or changes have been most meaningful in improving engagement, collaboration, or access to quality care? [\[Open Text Box\]](#)

36. Is there anything else you would like to share about your experiences with FE? If there is one thing that you could change, what would that be? [\[Open Text Box\]](#)

[\[Submit Button Appears on this Page\]](#)

[\[Page Break\]](#)

Post-Survey Landing Page [\[Appears After Respondents Hit Submit Button.\]](#)

Thank you for completing the survey. Your time and insights are greatly appreciated and will meaningfully inform the ongoing evaluation of the Facility Engagement initiative.

For questions or follow-up related to FE activities, please contact the Facility Engagement team at engagement@doctorsofbc.ca.

For questions about the evaluation, please contact SRDC at jpayne@srdc.org.

APPENDIX D: SURVEY TABLES

Table 1 Statistics by Health Authority

#	QUESTION WORDING	% OF RESPONDENTS WHO AGREED OR STRONGLY AGREED					
		Fraser	Interior	Island	Northern	PHSA	VCH & PHC
M	Edmondson's Psychological Safety Scale (Items 18-21)						
	<i>Mean</i>	0.87	0.92	0.88	1.02	1.00	0.92
M	Communication Subscale (Items 22-23)						
	<i>Mean</i>	0.64	0.71	0.71	0.61	0.62	0.64
M	aMBI HSS (MP) Personal Accomplishment (Items 31-34)						
	<i>Mean</i>	4.79	4.94	4.97	5.17	4.61	4.63
7	Has clear measures to assess and communicate the impacts of its activities to members and partners.	70	68	61	70	71	73
8	Represents the priorities and collective interests of its members.	86	84	80	87	84	89
9	Provides opportunities to participate in quality or system improvement initiatives.	84	80	77	78	81	85
10	Informs its members about MSA activities, opportunities, and decisions.	86	83	80	84	84	88
	I have observed MSA activities that... (Stem for 11-16)						
11	Address issues related to timely access to quality care.	64	63	62	71	59	64
12	Help identify and address barriers to delivering high quality patient care.	76	79	81	83	73	78
13	Optimize the use of resources or reduce unnecessary effort.	59	61	58	64	54	61
14	Address equity issues through allocation of resources (e.g. rural access, cultural safety, inclusive participation).	56	63	63	74	60	59
15	Help improve collaboration across different physician groups or departments.	90	85	86	85	88	88
16	Result in improvements to patients' overall health and well-being (e.g., better management of physical, mental, or behavioural health needs) through improved access to care.	66	67	69	64	66	71
17	When working within my MSA, I feel...I belong to a collaborative, patient-centered MSA.	76	79	71	85	68	77
24	I have seen examples of collaborative decision-making between my MSA and the Health Authority.	72	71	67	64	70	61
25	Health Authority leaders communicate the health authority's plans to MSAs in a clear and timely way.	38	36	30	54	52	46
26	I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients.	50	48	43	64	63	58
27	I understand how to engage with the Health Authority through the MSA.	52	45	45	68	55	51
	Over the past year, current collaboration between MSAs and Health Authorities... (Stem for 28-30)						
28	Reduces unnecessary costs while maintaining quality care at the system level.	45	43	45	44	48	46
29	Improves the consistent use of clinical guidelines.	51	49	40	50	51	47
30	Improves the consistent use of evidence-informed care pathways.	47	44	38	52	46	45

Note. Italicized numbers are means. No significant differences were found by Health Authority.

Table 2 Statistics by role

#	QUESTION WORDING	% OF RESPONDENTS WHO AGREED OR STRONGLY AGREED			
		Family physician	Specialist physician	Another type of HCP	Not a HCP
M	Edmondson's Psychological Safety Scale (Items 18-21)				
	<i>Mean</i>	1.05	0.81		
M	Communication Subscale (Items 22-23)				
	<i>Mean</i>	0.82	0.55		
M	aMBI HSS (MP) Personal Accomplishment (Items 31-34)				
	<i>Mean</i>	5.04	4.74		
7	Has clear measures to assess and communicate the impacts of its activities to members and partners.	72	64	66	54
8	Represents the priorities and collective interests of its members.	88	82	78	77
9	Provides opportunities to participate in quality or system improvement initiatives.	85	79	75	76
10	Informs its members about MSA activities, opportunities, and decisions.	88	81	85	57
	I have observed MSA activities that... (Stem for 11-16)				
11	Address issues related to timely access to quality care.	71	59	64	64
12	Help identify and address barriers to delivering high quality patient care.	86	74	76	77
13	Optimize the use of resources or reduce unnecessary effort.	69	53	53	69
14	Address equity issues through allocation of resources (e.g. rural access, cultural safety, inclusive participation).	73	55	62	60
15	Help improve collaboration across different physician groups or departments.	90	85	83	83
16	Result in improvements to patients' overall health and well-being (e.g., better management of physical, mental, or behavioural health needs) through improved access to care.	74	63	65	69
17	When working within my MSA, I feel...I belong to a collaborative, patient-centered MSA.	79	72		
24	I have seen examples of collaborative decision-making between my MSA and the Health Authority.	73	64	78	80
25	Health Authority leaders communicate the health authority's plans to MSAs in a clear and timely way.	40	37	59	71
26	I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients.	60	44	72	71
27	I understand how to engage with the Health Authority through the MSA.	60	45	49	69
	Over the past year, current collaboration between MSAs and Health Authorities... (Stem for 28-30)				
28	Reduces unnecessary costs while maintaining quality care at the system level.	52	39	42	45
29	Improves the consistent use of clinical guidelines.	52	44	51	64
30	Improves the consistent use of evidence-informed care pathways.	52	39	55	64

Note. HCP = health care provider. Italicized numbers are means. No significant differences were found by role.

Table 3 Statistics by familiarity with the Facility Engagement (FE) Initiative

#	QUESTION WORDING	% OF RESPONDENTS WHO AGREED OR STRONGLY AGREED					
		Not at all familiar	Slightly familiar	Somewhat familiar	Moderately familiar	Very familiar	Sig χ^2
M	Edmondson's Psychological Safety Scale (Items 18-21)						
	Mean	0.37	0.36	0.60	0.97	1.30	
M	Communication Subscale (Items 22-23)						
	Mean	0.20	0.09	0.46	0.71	1.00	
M	aMBI HSS (MP) Personal Accomplishment (Items 31-34)						
	Mean	4.80	4.65	4.87	4.81	4.99	
7	Has clear measures to assess and communicate the impacts of its activities to members and partners.	45	41	60	73	80	*
8	Represents the priorities and collective interests of its members.	67	65	79	87	88	*
9	Provides opportunities to participate in quality or system improvement initiatives.	57	68	75	84	90	*
10	Informs its members about MSA activities, opportunities, and decisions.	62	70	83	87	91	*
I have observed MSA activities that... (Stem for 11-16)							
11	Address issues related to timely access to quality care.	40	37	59	69	75	*
12	Help identify and address barriers to delivering high quality patient care.	75	58	70	81	84	*
13	Optimize the use of resources or reduce unnecessary effort.	41	34	50	66	71	*
14	Address equity issues through allocation of resources (e.g. rural access, cultural safety, inclusive participation).	46	40	53	65	74	*
15	Help improve collaboration across different physician groups or departments.	70	65	81	89	92	*
16	Result in improvements to patients' overall health and well-being (e.g., better management of physical, mental, or behavioural health needs) through improved access to care.	45	45	60	74	78	*
17	When working within my MSA, I feel...I belong to a collaborative, patient-centered MSA.	57	59	66	80	85	*
24	I have seen examples of collaborative decision-making between my MSA and the Health Authority.	50	56	60	65	77	*
25	Health Authority leaders communicate the health authority's plans to MSAs in a clear and timely way.	29	27	37	40	42	
26	I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients.	47	45	51	51	57	
27	I understand how to engage with the Health Authority through the MSA.	29	32	43	52	66	*
Over the past year, current collaboration between MSAs and Health Authorities... (Stem for 28-30)							
28	Reduces unnecessary costs while maintaining quality care at the system level.	33	19	45	43	49	
29	Improves the consistent use of clinical guidelines.	20	26	50	48	51	
30	Improves the consistent use of evidence-informed care pathways.	33	28	45	44	52	*

Note. Italicized numbers are means. An (*) indicates the χ^2 is significant at $p < .001$.

Table 4 Statistics by level of involvement in the work of the Medical Staff Association (MSA)

#	QUESTION WORDING	% OF RESPONDENTS WHO AGREED OR STRONGLY AGREED					Sig χ^2
		Not at all involved	Slightly involved	Somewhat involved	Moderately involved	Very involved	
M	Edmondson's Psychological Safety Scale (Items 18-21)						
	<i>Mean</i>	0.36	0.73	1.12	1.34	1.64	
M	Communication Subscale (Items 22-23)						
	<i>Mean</i>	0.12	0.54	0.87	1.09	1.27	
M	aMBI HSS (MP) Personal Accomplishment (Items 31-34)						
	<i>Mean</i>	4.73	4.73	4.99	4.92	5.18	
7	Has clear measures to assess and communicate the impacts of its activities to members and partners.	49	61	82	82	84	*
8	Represents the priorities and collective interests of its members.		73	86	91	94	*
9	Provides opportunities to participate in quality or system improvement initiatives.	65	81	91	93	93	*
10	Informs its members about MSA activities, opportunities, and decisions.	69	85	93	97	95	*
	I have observed MSA activities that... (Stem for 11-16)						
11	Address issues related to timely access to quality care.	43	60	72	82	86	*
12	Help identify and address barriers to delivering high quality patient care.		66	78	86	90	*
13	Optimize the use of resources or reduce unnecessary effort.	38	53	68	80	82	*
14	Address equity issues through allocation of resources (e.g. rural access, cultural safety, inclusive participation).	45	52	70	77	85	*
15	Help improve collaboration across different physician groups or departments.		77	88	95	93	*
16	Result in improvements to patients' overall health and well-being (e.g., better management of physical, mental, or behavioural health needs) through improved access to care.	46	66	76	87	87	*
17	When working within my MSA, I feel...I belong to a collaborative, patient-centered MSA.	52	74	87	92	97	*
24	I have seen examples of collaborative decision-making between my MSA and the Health Authority.		58	71	71	80	*
25	Health Authority leaders communicate the health authority's plans to MSAs in a clear and timely way.		33	36	44	48	
26	I trust that MSA and Health Authority leadership act collaboratively in the best interests of providers and patients.	47	45	57	59	64	*
27	I understand how to engage with the Health Authority through the MSA.	38	41	57	64	76	*
	Over the past year, current collaboration between MSAs and Health Authorities... (Stem for 28-30)						
28	Reduces unnecessary costs while maintaining quality care at the system level.		32	42	53	53	*
29	Improves the consistent use of clinical guidelines.		38	48	54	56	
30	Improves the consistent use of evidence-informed care pathways.	32	40	50	58	59	*

Note. Italicized numbers are means. An (*) indicates the χ^2 is significant at $p < .001$.

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