Doctors of BC

Final Evaluation of Specialist Services Committee Initiatives

Final Report

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TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

THE SPECIALIST SERVICES COMMITTEE AND ITS INITIATIVES

Established in 2006, the Specialist Services Committee (SSC) aims "to facilitate collaboration between the Government of BC, Doctors of BC and the Health Authorities on the delivery of Specialist services, and to support the improvement of the Specialist care system."[1]

The SSC has been allocated $20 million in 2010/11 and an additional $25 million in 2011/12 for a total of $45 million in the second year. The targeted funding falls under the 2009 Memorandum of Agreement (MOA) to enhance and expand programs that support the delivery of high quality specialty services in BC.

The 2012 Physician Master Agreement (PMA) allocated additional annual funding amounts to the SSC as follows:

- An additional $10 million in annual funding to be made available effective April 1, 2012.
- An additional $8 million in annual funding to be made available effective April 1, 2013.

With this funding, the SSC implemented several initiatives that are a combination of new fees, training modules and activities to enhance the quality of, and improve appropriate patient access to, Specialist physician services.

THE PURPOSE AND SCOPE OF THE FINAL EVALUATION

The overall objective of this final evaluation was to assess the relevance and performance of six SSC initiatives (described in the following table) and to determine whether the initiatives have achieved their overall intended goals and objectives. Where possible, the final evaluation assessed the levels of impact and change that have been achieved since MNP's mid-term evaluation.

The SSC may utilize the outcome evaluation findings to:[2]

- Determine what lessons have been learned.
- Make recommendations for future project development and improvement.
- Guide decision making for future SSC funding considerations.

The table following provides summaries of the six SSC initiatives evaluated in the final evaluation. More detailed descriptions of each initiative are provided in **Section 5** of the report.

SSC Initiative	Description
1. Complex Care Discharge Planning Fee	A fee developed to improve the information that is documented when a complicated patient is discharged from hospital to ensure there is proper follow-up and coordination of patient care and management. This may involve the development of a discharge plan in coordination with other health care providers, including a patient's family physician.
2. Group Medical Visit (GMV) Fees for Specialists	GMVs are intended to provide an effective way of leveraging existing resources while simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. GMV Fees are billable by Specialists that have completed, or that are currently enrolled in, the Practice Support Program module for Specialists on Advanced Access and GMVs.
3. Labour Market Adjustment (LMA)	As of fiscal year 2012/13, about $10 million has been awarded to nine Sections to implement LMA fee items aimed at addressing

[1] Specialist Services Committee Presentation to the Quality Forum. February 28, 2014. http://qualityforum.ca/wp-content/uploads/2014/03/SSC-Presentation-to-Quality-Council-Feb-2014-v2.pdf
[2] SSC Program Inception Report April 15, 2010.

SSC Initiative	Description
initiative	recruitment and retention pressures. Funding allocations were based on the recommendations of an independent LMA Advisory Committee. A total of 43 new fee codes were created and implemented during the summer of 2011. While two sections have exceeded their allocation during the monitoring period, all other sections are within or under budget. As a result, various adjustments, to LMA fee items, have been made by the SSC, the Doctors of BC and the Ministry of Health.
4. Health Authority Redesign Funding initiative	The Health Authorities System Redesign initiative involves the compensation of Specialists that have been asked to participate in health system redesign initiatives led by the Health Authorities.
5. Physician Scholarship Funding initiative	To promote and/or further the work being undertaken within each health authority on behalf of the health authority redesign initiative, the SSC has committed to fund scholarships for training of Specialists to enhance the redesign experience and outcomes, and to support their professional growth. Funding towards leadership training scholarships covers tuition and travel costs.
6. Specialist Advanced Care Planning Fee	Advance Care Planning is when a capable adult thinks about, and discusses, their beliefs, values and wishes for future health care, in the event the adult becomes incapable of making such decisions in the future. When an adult's wishes are written down, they become an Advance Care Plan. This objective of the Advanced Care Planning Fee is to encourage Specialists to have discussions with their patients about Advance Care Planning.

EVALUATION METHODOLOGY AND APPROACH

The final evaluation of SSC initiatives did not target the entire BC Specialist population, but rather focused on Sections that were identified as being users and non-users of SSC initiatives. The data collection for the final evaluation took place from April to July of 2014, and involved both primary and secondary research.

Primary Research

The primary research tools used by MNP to assess stakeholder perceptions were:

- **Two web-based surveys of targeted Sections (high users and low users).** In collaboration with the SSC and its Working Group, MNP developed two web-based surveys for targeted Sections. The surveys were used to assess utilization of the Complex Care Discharge Planning Fee and the Specialist Advanced Care Planning Fee among Sections deemed as 'high users' of the fees, as well as among Sections deemed as 'low users' of the fees. The Complex Care Discharge Planning Fee survey yielded 218 respondents, and the Specialist Advanced Care Planning Fee yielded 82 respondents. A profile of survey respondents is included in **Section 5.1**.
- **Telephone interviews with Specialists, Section Heads and Economic Leads, and Health Authority representatives.** To assess the effects of the GMV Fees for Specialists, LMA initiative, Health Authority Redesign Funding initiative and the Physician Scholarship Funding initiative, MNP interviewed a total of 40 representatives of various Sections and Health Authorities. A profile of interview respondents is included in **Section 5.1**.

  The individual data collection tools and questions can be viewed in **Appendix A**.

Secondary Research

Secondary research conducted by MNP for the evaluation included:

- **A Document Review.** The document review consisted of a review of existing resources including the SSC Inception Report and SSC annual reports. A high level review of initiative-specific background documentation was also conducted using publically available documents, as well as information received from the Doctors of BC.
- **A Review of MSP Data – Fee Utilization Trends.** To identify Sections that were high and low users of the Complex Care Discharge Planning Fee and the Specialist Advanced Care Planning Fee codes, MNP reviewed fee utilization data across Sections. Data on fee utilization was obtained from the Doctors of BC for the GMV Fees for Specialists and the new fee codes that originated through the LMA Funding initiative.

Evaluation Design

The final evaluation was designed to address the following questions:

1. **Implementation.** Have the initiatives been implemented in an effective manner?
2. **Achievement of Objectives.** To what degree have the initiatives achieved their intended objectives?
3. **Success and Constraining Factors.** What factors contribute to and/or constrain the effectiveness of the initiatives?
4. **Unintended Consequences.** Are there any unintended (positive or negative) consequences occurring as a result of the initiatives?
5. **Improvement Opportunities.** Are there opportunities for improvement?

Section 4.1 of the report summarizes the specific evaluation issues and indicators, as well as evaluation methods employed, for each SSC initiative.

KEY FINDINGS BY INITIATIVE

1. Complex Care Discharge Planning Fee

The key final evaluation findings for the Complex Care Discharge Planning Fee were:

- While the majority (82%) of survey respondents had prior experience with developing a discharge plan, they were largely either unfamiliar or only somewhat familiar with the Complex Care Discharge Planning Fee.
- The utilization of the Complex Care Discharge Planning Fee varied among respondents, and the majority (86%) of respondents did not bill it for all of their complex patients.
- The main reasons for not billing for the Complex Care Discharge Planning Fee were lack of familiarity with the appropriate billing procedures, the billing process (which was perceived to be onerous by survey respondents) and the perceived inapplicability of the fee to Specialists' roles, practices or situations.
- Unexpected outcomes that arose from the Complex Care Discharge Planning Fee included an increase in satisfaction among primary care providers and patient families with receiving written discharge care plans, and improved communication between Specialists and primary care providers.

2. Group Medical Visit Fees for Specialists

The key final evaluation findings for the Group Medical Visit Fees for Specialists were:

- The uptake of GMV Fees for Specialists continued to be slow. Total utilization is highest for GMVs that include smaller groups of patients.
- The composition of GMVs across interview respondents varied. When describing the key characteristics, elements, and/or supports that make GMVs an effective part of their practice, respondents cited the inclusion of allied health professionals, involvement of other Specialists, improved patient access to care, group dynamics time and cost efficiencies.

- Although respondents deemed the GMV fee levels as inappropriate, most reported that they would likely claim the GMV Fees for Specialists in the future.
- According to respondents, the GMV Fees for Specialists could be improved by increasing the current fee levels. Respondents also agreed unanimously that patient and physician awareness of GMVs should be improved.

3. Labour Market Adjustment Initiative

The key final evaluation findings for the Labour Market Adjustment initiative were:

- Interviews with Section Heads and Economic leads of the Sections that obtained funding through the LMA initiative suggested that the initiative has made progress towards reducing pressures associated with recruitment and retention.
- Respondents were generally satisfied with the overall process implemented by the SSC to address labour market adjustments, as well as with the review panel process that was implemented.
- According to respondents, the fees created as a result of the LMA initiative have incentivized Specialists to collaborate with allied health professionals, to implement new techniques and to utilize telephone or virtual follow-ups as part of their patient consults.
- Respondents noted that a lack of initial understanding of the implications and consequences of under or over-utilization of fee codes implemented through the LMA initiative affected Section proposals.
- Respondents stated that the LMA initiative could be improved further by ensuring the availability of ongoing funding as the utilization of new fee codes rises.

4. Health Authority Redesign Funding Initiative

The key final evaluation findings for the Health Authority Redesign Funding initiative were:

- The majority of Specialists interviewed learned about the initiative through their respective Health Authority. Health Authority Representatives interviewed reported that the most common means of engaging Specialists was by communicating that their time is compensated. The compensation of physicians through sessional payments defrays some of the opportunity cost of putting aside clinical hours to participate in the initiative.
- Respondents were engaged in a variety of activities, ranging from e-Health program development and promotion to participation in cross-disciplinary care. Specialists interviewed reported that they were very likely to participate in the initiative again.
- Findings suggested that the initiative is contributing to increased interactions and collaboration between Specialists and Health Authorities.
- Respondents recommended multi-year or renewable funding as well as increased funding to ensure the financial sustainability of projects.

5. Physician Scholarship Funding Initiative

The key final evaluation findings for the Physician Scholarship Funding initiative were:

- Specialists that participated in the Physician Scholarship Funding initiative generally expressed high satisfaction with it.
- The majority of Specialists that participated in the Physician Scholarship Funding initiative used the funding to attend leadership and strategic planning training. The majority of respondents were also satisfied with the flexibility to choose their own leadership courses and conferences, as it provided them with an opportunity to choose initiatives that were suitable to their individual learning needs.
- All respondents reported having gained new skills that they have been able to apply in their own roles and in working with their colleagues and respective Health Authorities.
- Respondents expressed concern regarding the limit on the level of funding for accommodation during courses or conferences attended through the initiative.

- The most commonly reported suggestion for improvement was increasing communication regarding awareness of the initiative. According to respondents, the initiative is not widely known by Specialists, and further efforts are needed to increase awareness of it.

6. Specialist Advanced Care Planning Fee

The key final evaluation findings for the Specialist Advanced Care Planning Fee were:

- The majority (84%) of survey respondents had experience with Advanced Care Planning and plan development, and most (74%) reported being "comfortable" or "very comfortable" with having Advanced Care Planning discussions with their patients.
- Nonetheless, survey results demonstrated that respondents were largely unfamiliar with the Specialist Advanced Care Planning fee, and 72% had never billed/claimed the fee. About a third (33%) of respondents did not bill for the fee because they were unfamiliar with the appropriate billing procedures.
- Almost half (47%) of respondents that were compensated on a fee-for-service (FFS) payment arrangement perceived the fee to be inappropriate.
- Nonetheless, respondents generally perceived the fee as useful in assisting with Advance Care Planning.
- The most commonly reported suggestions for improvement included increasing the fee to a level that is commensurate with the time expended (e.g. time-based fee); increasing marketing efforts to enhance awareness of the fee among Specialists; and, providing more upfront information regarding the specific fee requirements and documentation.

KEY CONCLUSIONS AND RECOMMENDATIONS

MNP's overall conclusions and recommendations fall into three categories:

1. Communication and marketing of SSC initiatives.
2. Collaboration and consultation with allied health professionals.
3. Ongoing performance measurement.

1. Communication and marketing of SSC initiatives

- Consistent with MNP's mid-term evaluation findings, Specialists' unfamiliarity with SSC initiatives limits their uptake.
- Widespread, focused marketing efforts could improve uptake of SSC initiatives and increase the likelihood of achieving the program objectives. Ensuring that Specialists are informed of the purpose, priorities and scope of initiatives may result in fewer barriers to agreement and increased adoption among Specialists.
- The majority of survey and interview respondents stated that the most effective means of communication with the SSC is twice monthly email updates. The SSC should consider focusing future marketing efforts and dissemination of relevant initiative-specific information through email communication.
- To improve communication and marketing of initiatives, we suggest the SSC:
    - Clearly articulate program objectives, potential benefits and appropriate billing procedures, and create effective marketing materials.
    - Engage Specialists through encouraging word-of-mouth communication, especially by Specialists that utilize or participate in SSC initiatives.
    - Engage Sections individually through Section newsletters and e-blasts, as well as by identifying and utilizing Specialists within each Section to articulate and promote the initiatives.

2. Collaboration and consultation with allied health professionals

- Opportunities exist to improve collaboration and consultation among allied health professionals. Although the outcome evaluation findings suggest that some of SSC initiatives have contributed to increasing collaboration between Specialists and Health Authorities and health professionals, many interview respondents highlighted the need for more cooperation in this regard.
- We recommend that the SSC create additional opportunities to increase collaboration and knowledge-exchange between Specialists and allied health professionals. Annual face-to-face meetings, regular email communication and website updates and publications are some of the ways in which information exchange and collaboration could be facilitated.

3. Ongoing performance measurement

- We recommend the development and implementation of an ongoing performance measurement system that is aligned with the Triple Aim Initiative, the SSC's guiding principles and initiative specific objectives. Such system may be particularly beneficial with monitoring and forecasting future fee code utilization.
- Ongoing performance monitoring and regular progress updates to the SSC would help to inform committee representatives, as well as to increase accountability and to instigate appropriate action based on reported results.
- We recommend that processes and procedures for reporting and performance measurement be revised and streamlined.
- We suggest that an evaluation update in the form of a 'reporting dashboard' be prepared for, and circulated among, the SSC on a quarterly or bi-annual basis. Such a tool would provide a summary of the status and key highlights of each of the committee's initiatives.

2 INTRODUCTION

2.1 BACKGROUND

The Specialist Services Committee

Established in 2006, the Specialist Services Committee (SSC) aims "to facilitate collaboration between the Government of BC, Doctors of BC and the Health Authorities on the delivery of Specialist services, and to support the improvement of the Specialist care system."[3]

The SSC has been allocated $20 million in 2010/11 and an additional $25 million in 2011/12 for a total of $45 million in the second year. The targeted funding falls under the 2009 Memorandum of Agreement (MOA) to enhance and expand programs that support the delivery of high quality specialty services in BC.

SSC Mandate:

To facilitate collaboration with the Government of BC, Doctors of BC and the Health Authorities on the delivery of Specialist services, and to support the improvement of the Specialist care system.

The 2012 Physician Master Agreement (PMA) allocated additional annual funding amounts to the SSC as follows:

- An additional $10 million in annual funding to be made available effective April 1, 2012.
- An additional $8 million in annual funding to be made available effective April 1, 2013.

With this funding, the SSC implemented several initiatives that are a combination of new fees, training modules, and activities to enhance the quality of, and improve appropriate patient access to, Specialist physician services.

The Final Evaluation of SSC Initiatives

MNP LLP (MNP) was engaged to carry out a multi-year evaluation of SSC initiatives. The evaluation consisted of three phases. In **Phase 1**, a detailed evaluation methodology was developed. **Phase 2** consisted of a mid-term evaluation that provided an interim assessment of the progress made within the first year of the initiatives (2010/11). **Phase 3**, the current phase, consisted of a final evaluation of six SSC initiatives.

For a detailed overview of the first two phases, and the steps taken by MNP to carry out the mid-term evaluation, please refer to MNP's mid-term evaluation report.[4]

[3] Specialist Services Committee Presentation to the Quality Forum. February 28, 2014. http://qualityforum.ca/wp-content/uploads/2014/03/SSC-Presentation-to-Quality-Council-Feb-2014-v2.pdf
[4] MNP's Mid-Term Evaluation of SSC initiatives http://www.sscbc.ca/sites/default/files/SSC_Mid_Eval_FinalReport.pdf

2.2 PURPOSE AND SCOPE OF THE FINAL EVALUATION

Purpose

The purpose of the final evaluation was to assess the relevance and performance of six SSC initiatives (described in the **Section 3.2**), and to determine whether the initiatives have achieved their overall intended goals. Where possible, the final evaluation assessed the levels of impact and change that have been achieved since MNP's mid-term evaluation.

Scope

The final evaluation assessed the following six SSC initiatives.

1. Complex Care Discharge Planning Fee.
2. Group Medical Visit (GMV) Fees for Specialists.
3. Labour Market Adjustment (LMA) initiative.
4. Physician Scholarship Funding initiative.
5. Health Authority Redesign Funding initiative.
6. Specialist Advanced Care Planning Fee.

For a description of each initiative, please refer to **Section 3.2**.

2.3 STRUCTURE OF THE REPORT

In this document we present the methodology and final evaluation findings. The remainder of this document contains the following chapters:

- **Chapter II** provides an overview of the SSC, including a description of the Committee, its initiatives and 2013/14 budget.
- **Chapter III** describes the methodology and approach employed for the evaluation.
- **Chapter IV** presents the evaluation findings. It also includes a profile of respondents and summarizes future SSC communication preferences expressed by respondents.
- **Chapter V** synthesizes the key findings and recommendations of the evaluation.

The appendices to the report contain data collection tools, a list of fee codes created and implemented through LMA funding, and an example of a performance monitoring dashboard.

3 OVERVIEW OF THE SPECIALIST SERVICES COMMITTEE

3.1 OVERVIEW OF THE SPECIALIST SERVICES COMMITTEE

The SSC has implemented several initiatives to enhance the quality of, and improve appropriate patient access to, Specialist care services. The SSC's areas of focus include:[5]

- Closing gaps in Specialist care for patients and communities.
- Supporting improved care for patients with complex or chronic conditions.
- Using innovative means to provide increased access to care including telehealth, telephone advice, e-mail and online consultations.
- Expanding clinical prevention activities.
- Working to recruit and retain Specialists in BC.

When considering ideas for implementation, the SSC utilizes the Institute for Healthcare Improvement's Triple Aim Initiative, the SSC's own guiding principles, and specific program objectives as tools for developing the initiatives. The Triple Aim Initiative and SSC's guiding principles are described below.

Triple Aim Initiative[6]

The Institute for Healthcare Improvement's Triple Aim Initiative communicates three system-wide goals that are intended to lead to more coordinated, integrated and comprehensive patient care:

- The model/approach impacts positively the experience of the individual (i.e. the individual can receive the care that they exactly want and need, and how they exactly want and need it).
- The model/approach impacts positively the health (physical and mental) of a defined population.
- The per capita cost of the model/approach has a positive effect on health care cost/spending.

The SSC's Guiding Principles[7]

The SSC's guiding principles are:

- Address care gaps (improve the health of a defined population).
- Improve/benefit patient experience by improving and supporting patient engagement.
- Improve/benefit provider experience by:
  - Improving knowledge, skills and judgements of individual physicians that will positively affect patient management and outcomes.
  - Improving collaborative practice.
- Encourage efficient capacity.
- Encourage appropriate access to care.
- Demonstrate a positive cost benefit.
- Demonstrate an achievable, measurable outcome.

[5] Specialist Services Committee Report for the Period 2010/11 and 2011/12. http://www.sscbc.ca/sites/default/files/SSC_AR%20WEB_0.pdf
[6] SSC Program Inception April 2010.
[7] Ibid.

3.2 DESCRIPTION OF SSC INITIATIVES

The following table provides summaries of the six SSC initiatives evaluated in the final evaluation. More detailed descriptions of each initiative are provided in **Section 5** of the report.

SSC Initiative	Description
1. Complex Care Discharge Planning Fee	A fee developed to improve the information that is documented when a complicated patient is discharged from hospital to ensure there is proper follow-up and coordination of patient care and management. This may involve the development of a discharge plan in coordination with other health care providers, including a patient's family physician.
2. Group Medical Visit Fees for Specialists	GMVs are intended to provide an effective way of leveraging existing resources while simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. GMV Fees are billable by Specialists that have completed, or that are currently enrolled in, the Practice Support Program module for Specialists on Advanced Access and GMVs.
3. Labour Market Adjustment initiative	As of fiscal year 2012/13, about $10 million has been awarded to nine Sections to implement LMA fee items aimed at addressing recruitment and retention pressures. Funding allocations were based on the recommendations of an independent LMA Advisory Committee. A total of 43 new fee codes were created and implemented during the summer of 2011. While two sections have exceeded their allocation during the monitoring period, all other sections are within or under budget. As a result, various adjustments, to LMA fee items, have been made by the SSC, the Doctors of BC and the Ministry of Health.
4. Health Authority Redesign Funding initiative	The Health Authorities System Redesign initiative involves the compensation of Specialists that have been asked to participate in health system redesign initiatives led by the Health Authorities.
5. Physician Scholarship Funding initiative	To promote and/or further the work being undertaken within each health authority on behalf of the health authority redesign initiative, the SSC has committed to fund scholarships for training of Specialists to enhance the redesign experience and outcomes, and to support their professional growth. Funding towards leadership training scholarships covers tuition and travel costs.
6. Specialist Advanced Care Planning Fee	Advance Care Planning is when a capable adult thinks about, and discusses, their beliefs, values and wishes for future health care, in the event the adult becomes incapable of making such decisions in the future. When an adult's wishes are written down, they become an Advance Care Plan. This objective of the Advanced Care Planning Fee is to encourage Specialists to have discussions with their patients about Advance Care Planning.

3.3 BUDGET

The following table summarizes the SSC's 2011/12 and 2012/13 budget allocations for the six initiatives under review.

SSC Initiative	Funding	
	2011/12	2012/13
Complex Care Discharge Planning Fee	$7,000,000	$2,300,000
Group Medical Visit Fees for Specialists	$ -	$2,000,000
Labour Market Adjustments	$10,000,000	$10,000,000
Health Authority Redesign Funding	$500,000	$696,896
Physician Scholarship Funding	$250,000	$250,000
Specialist Advanced Care Planning Fee	$ -	$1,500,000
Total Budget	**$17,750,000**	**$16,746,896**

4 EVALUATION METHODOLOGY AND APPROACH

4.1 EVALUATION DESIGN

The final evaluation of SSC initiatives focused on identified users and non-users of SSC initiatives. Primary research for the project took place from April to July of 2014 through telephone interviews and online surveys. Secondary research consisted of reviews of initiative-specific documentation and administrative data, and was also carried out from April to July of 2014. A description of the evaluation and data collection approach follows.

Primary Research

The primary research tools used to assess stakeholder perceptions included telephone interviews and online surveys.

- **Telephone interviews with Specialists, Section Heads and Economic Leads, and Health Authority representatives.** MNP interviewed a total of 40 representatives of various Sections and Health Authorities. The following table shows the number of respondents interviewed.

Number of Respondents Interviewed

Initiative	Specialists	Section Heads	Economic Leads	Health Authority Representatives
Group Medical Visit Fees for Specialists	5	-	-	-
Labour Market Adjustments initiative	-	8	2	-
Health Authority Redesign Funding initiative	8	-	-	9
Physician Scholarship Funding initiative	8	-	-	-
Total	**21**	**8**	**2**	**9**

- **Online surveys of targeted Sections.** In collaboration with the SSC and its Working Group, MNP developed two online surveys for targeted Sections. The purpose of the surveys was to assess the utilization of the Complex Care Discharge Planning Fee and the Specialist Advanced Care Planning Fee among Sections deemed as 'high users' of the fees, as well as among Sections deemed as 'low users' of the fees. The following tables show the number of Section representatives surveyed for each initiative.

Number of Respondents Surveyed

Complex Care Discharge Planning Fee		
Section	*"High" Users*	*"Low" Users*
Psychiatry	50	
Internal Medicine	39	
General Surgery		55
Cardiology		17
Other Sections[8]	57	
Total Number of Respondents	**218**	

[8] Other Sections that filled out the survey included: Cardiac Surgery, Infectious Diseases, Gastroenterology, Critical Care, Endocrinology, Geriatric Medicine, Rheumatology, Vascular Surgery, Haematology & Oncology, Respirology, and Nephrology.

Advanced Care Planning Fee		
Section	*"High" Users*	*"Low" Users*
Internal Medicine	23	
Nephrology	9	
Neurology		8
Cardiology		8
Other Sections[9]	34	
Total Number of Respondents	**82**	

The primary data collection tools are contained in **Appendix A**.

Secondary Research

Secondary research conducted by MNP for the evaluation included:

1. Document Review

The document review consisted of a review of the SSC Inception Report and annual reports. A high level review of initiative-specific background documentation was also conducted using publically available documents, as well as information received from the Doctors of BC.

2. MSP Data – Fee Utilization Trends

Based on a review of utilization data, Sections that were "high" versus "low" users of the Complex Care Discharge Planning Fee and the Specialist Advanced Care Planning Fee were identified. Additional data on fee utilization were obtained from the Doctors of BC for the GMV Fees for Specialists and the new fee codes that originated through the LMA Funding initiative.

Evaluation Design

The final evaluation was designed to address the following questions:

1. **Implementation.** Have the initiatives been implemented in an effective manner?
2. **Achievement of Objectives.** To what degree have the initiatives achieved their intended objectives?
3. **Success and Constraining Factors.** What factors contribute to and/or constrain the effectiveness of the initiatives?
4. **Unintended Consequences.** Are there any unintended (positive or negative) consequences occurring as a result of the initiatives?
5. **Improvement Opportunities.** Are there opportunities for improvement?

The following table summarizes the design for carrying out the final evaluation of SSC initiatives. It describes the specific evaluation issues and indicators, as well as evaluation methods employed, for each initiative.

[9] Other Sections that filled out the survey included: Allergy and Immunology, Critical Care, Endocrinology, Gastroenterology, Geriatric Medicine, Haematology & Oncology, Infectious Diseases, Paediatrics, Respirology, and Rheumatology.

SSC Initiatives	Evaluation Issues and Indicators	Primary Evaluation Method
1. Complex Care Discharge Planning Fee	• Qualifying questions • Frequency of billing • Reasons for not billing • Ways in which fee is billed (i.e. the Most Responsible Physician, etc.) • Appropriateness of fee level • Likelihood of billing fee again in the future • Effect on continuity and coordination of care • Effect on collaboration with other healthcare providers • Profile of complex patients billed for and not billed for • Usefulness in caring for complex patients • Unexpected results that arose from the fee • Most effective ways of SSC communication of fee	Online survey of targeted Sections (high users and low users)
2. Group Medical Visit Fees for Specialists	• Qualifying questions • Characteristics, utilization and frequency of Group Medical Visits • Appropriateness of fee level • Likelihood of billing fee again in the future • Effect on efficiency of care • Effect on patient access to, and continuity of, care • Effect on collaboration with other healthcare providers • Barriers to implementing Group Medical Visits • Most appropriate specialties for targeting Group Medical Visits • Unexpected results that arose from the fee • Most effective ways of SSC communication of fee	Telephone interviews with Specialists that have previously claimed the GMV Fees for Specialists or have completed the Practice Support Program (PSP) module
3. Labour Market Adjustments	• Qualifying questions • Satisfaction of Sections regarding the process • Factors contributing to, and constraining, success • Appropriateness of funding allocations • Effect of LMAs on Section recruitment and retention • Opportunities for improvement • Transferability of fees developed through LMA funding to other Sections	Telephone interviews with Section[10] Heads and their Economic Leads
4. Health Authority Redesign Funding	• Qualifying questions • Issues addressed by Specialists using this funding • Strategies to engage Specialists • Satisfaction with the engagement and reimbursement process	Telephone interviews with Specialists and Health Authority representatives

[10] Sections include Neurology, Obstetrics and Gyneocology, Internal Medicine, Anasthesia, Geriatrics Medicine, Rheumatology, Respirology, Endocrinology, Infectious Disease

SSC Initiatives	Evaluation Issues and Indicators	Primary Evaluation Method
	• Specialists' barriers to participation • Effect on relationships and collaboration between Specialists and Health Authorities • Extent to which initiative objectives were achieved • Factors contributing to, and constraining, success • Specialists' satisfaction with initiative outcomes • Likelihood of future participation in initiative • Unexpected results that arose from the initiative • Most effective ways of SSC communication of initiative	
5. Physician Scholarship Funding	• Qualifying questions • Leadership courses and/or conferences attended • New skills acquired and the application thereof • Satisfaction with the initiative • Barriers to participation • Appropriateness of funding allocations • Satisfaction with the process required to claim expenses • Likelihood of applying for physician scholarships again in the future • Most effective ways of SSC communication of initiative	Telephone interviews with Specialists that obtained funding through the initiative
6. Specialist Advanced Care Planning Fee	• Qualifying questions • Frequency of Advance Care Planning services provision • Reasons for not billing • Appropriateness of fee level • Likelihood of billing fee again in the future • Effect on continuity and coordination of care • Effect on collaboration with other healthcare providers • Usefulness in assisting with Advanced Care Planning • Level of Specialist comfort and preparation around having Advanced Care Planning discussions • Unexpected results that arose from the fee • Most effective ways of SSC communication of fee	Online survey of targeted Sections (high users and low users)

4.2 EVALUATION STRENGTHS AND LIMITATIONS

Evaluation Strengths

Some of the key features of the evaluation design were:

- **The use of multiple lines of evidence.** While the use of multiple lines of evidence to improve reliability and validity of findings is a common practice in evaluation, it was particularly important in this evaluation, given the diverse characteristics of SSC initiatives and the requirement to collect information on changes occurring at multiple levels (i.e. physician, health authority, community and provincial). As a result, MNP incorporated interviews with a variety of key stakeholder groups, including Specialists, Health Authority representatives and Section Heads.
- **Working collaboratively with the SSC.** MNP worked closely with the SSC to ensure that there was a strong commitment to the evaluation, and that MNP developed a strong understanding of the initiatives under review.
- **Use of both quantitative and qualitative data collection methods.** The evaluation design included both quantitative and qualitative data collection methods to provide a comprehensive assessment of the initiatives.
- **Tailored data collection instruments.** The data collection tools and the questions utilized in the final evaluation were tailored to each respondent group. This approach allowed MNP to collect more meaningful input regarding the SSC initiatives than would have been the case with a single standardized questionnaire.

Evaluation Limitations

The original plan for the final evaluation included an analysis of data from the MSP claims database. However, a detailed review of the database was found not to be necessary, as there had been little change in uptake since the mid-term evaluation. As a result, only summary reports (including the uptake of the new fee codes by specialty) pertaining to a few of the SSC initiatives were obtained and analyzed.

5 SUMMARY OF FINDINGS

5.1 PROFILE OF RESPONDENTS

The following tables present a profile of each initiative's respondent group.

Complex Care Discharge Planning Fee			
		Number	Percent
Number of Respondents	Female	77	36%
	Male	139	64%
	Total	216	100%
Section		***"High Users" – 89*** • Psychiatry – 50 • Internal Medicine – 39 ***"Low Users" – 72*** • General Surgery – 55 • Cardiology – 17 ***"Other" – 57***	***"High Users" – 40%*** • Psychiatry – 23% • Internal Medicine – 18% ***"Low Users" – 33%*** • General Surgery – 25% • Cardiology – 8% ***"Other" – 26%***
Number of Years Practicing as a Specialist	<1 to 3 years	30	14%
	4 to 6 years	30	14%
	7 to 10 years	24	11%
	11 to 15 years	37	17%
	Over 15 years	95	44%
Type of Practice	Primarily Hospital	140	65%
	Primarily Community	50	23%
	Other	26	12%
Health Authority practiced most often in	FHA	48	22%
	IHA	24	11%
	NHA	9	4%
	PHSA	16	7%
	VCHA	67	31%
	VIHA	52	24%

Group Medical Visit Fees for Specialists			
		Number	Percent
Number of Respondents	Female	1	20%
	Male	4	80%
	Total	5	100%
Section		• Pediatrics – 1 • Cardiology – 2 • Psychiatry – 2	• Pediatrics – 20% • Cardiology – 40% • Psychiatry – 40%
Number of Years Practicing as a Specialist	<1 to 3 years	0	0%
	4 to 6 years	0	0%
	7 to 10 years	1	20%
	11 to 15 years	0	0%
	Over 15 years	4	80%
Type of Practice	Primarily Hospital	2	40%
	Primarily Community	3	60%
	Other	0	0%

Group Medical Visit Fees for Specialists			
		Number	Percent
Health Authority practiced most often in	FHA	1	20%
	IHA	0	0%
	NHA	0	0%
	PHSA	0	0%
	VCHA	2	40%
	VIHA	2	40%
Form of Compensation Arrangements	Fee-for-service	5	100%
	Alternative Payment arrangements	0	0%

Labour Market Adjustment Initiative			
		Number	Percent
Number of Respondents	Female	1	10%
	Male	9	90%
	Total	10	100%
Section		• Neurology – 1 • OB/GYN – 2 • CRIM – 1 • Geriatric Med – 1 • Rheumatology – 1 • Respirology – 2 • Endocrinology – 1 • Infectious Diseases – 1	• Neurology – 10% • OB/GYN – 20% • CRIM – 10% • Geriatric Med – 10% • Rheumatology – 10% • Respirology – 20% • Endocrinology – 10% • Infectious Diseases – 10%

Health Authority Redesign Funding Initiative (Specialists)			
		Number	Percent
Number of Respondents	Female	3	37%
	Male	5	63%
	Total	8	100%
Section		• Psychiatry – 1 • Emergency Medicine – 1 • Paediatrics – 2 • Neurology – 1 • Anaesthesiology – 1 • Nephrology – 1 • Family Medicine – 1	• Psychiatry – 13% • Emergency Medicine - 13% • Paediatrics – 25% • Neurology – 13% • Anaesthesiology – 12% • Nephrology – 12% • Family Medicine – 12%
Number of Years Practicing as a Specialist	<1 to 3 years	0	0%
	4 to 6 years	0	0%
	7 to 10 years	0	0%
	11 to 15 years	2	25%
	Over 15 years	6	75%
Type of Practice	Primarily Hospital	8	100%

Health Authority Redesign Funding Initiative (Specialists)			
		Number	Percent
Health Authority practiced most often in	Primarily Community		
	Other		
	FHA	0	0%
	IHA	3	38%
	NHA	1	13%
	PHSA	1	12%
	VCHA	1	12%
	VIHA	2	25%

Health Authority Redesign Funding Initiative (Health Authority Project Leads)			
		Number	Percent
Number of Respondents	Female	5	56%
	Male	4	44%
	Total	9	100%
Health Authority practiced most often in	FHA	0	0%
	IHA	2	22%
	NHA	2	22%
	PHSA	1	12%
	VCHA	2	22%
	VIHA	2	22%

Physician Scholarship Funding Initiative			
		Number	Percent
Number of Respondents	Female	5	63%
	Male	3	37%
	Total	8	100%
Section		• Psychiatry – 2 • Oncology – 1 • Ophthalmology – 1 • Anesthesiology – 1 • Emergency Medicine – 1 • Medical Microbiology – 1 • Cardiology – 1	• Psychiatry – 25% • Oncology – 13% • Ophthalmology – 13% • Anesthesiology – 13% • Emergency Medicine – 12% • Medical Microbiology – 12% • Cardiology – 12%
Number of Years Practicing as a Specialist	<1 to 3 years	0	0%
	4 to 6 years	1	12%
	7 to 10 years	0	0%
	11 to 15 years	2	25%
	Over 15 years	5	63%
Type of Practice	Primarily Hospital	7	87%
	Primarily Community	1	13%
	Other	0	0%
Health Authority practiced most often in	FHA	1	13%
	IHA	1	13%
	NHA	0	0%
	PHSA	2	25%

Physician Scholarship Funding Initiative			
Leadership Position in Health Authority	VCHA	1	12%
	VIHA	3	37%
	Yes	7	88%
	No	1	12%
Form of Compensation Arrangements	Fee-for-service	3	38%
	Alternative Payment arrangements	5	62%

Specialist Advanced Care Planning Fee			
		Number	**Percent**
Number of Respondents	Female	25	30%
	Male	57	70%
	Total	82	100%
Section<		***"High Users" – 32*** • Internal Medicine – 23 • Nephrology – 9 ***"Low Users" – 16*** • Neurology – 8 • Cardiology – 8 ***"Other" – 34***	***"High Users" – 39%*** • Internal Medicine – 28% • Nephrology – 11% ***"Low Users" – 20%*** • Neurology – 10% • Cardiology – 10% ***"Other" – 41%***
Number of Years Practicing as a Specialist	<1 to 3 years	18	22%
	4 to 6 years	10	12%
	7 to 10 years	10	12%
	11 to 15 years	12	15%
	Over 15 years	32	39%
Type of Practice	Primarily Hospital	49	60%
	Primarily Community	24	29%
	Other	9	11%
Health Authority practiced most often in	FHA	24	29%
	IHA	6	7%
	NHA	1	1%
	PHSA	11	13%
	VCHA	26	32%
	VIHA	14	17%

5.2 COMPLEX CARE DISCHARGE PLANNING FEE

Key Findings

The key final evaluation findings for the Complex Care Discharge Planning Fee were:

- **While the majority (82%) of survey respondents had prior experience with developing a discharge plan, they were largely either unfamiliar or only somewhat familiar with the Complex Care Discharge Planning Fee.**
- **The utilization of the Complex Care Discharge Planning Fee varied among respondents, and the majority (86%) of respondents did not bill it for all of their complex patients.**
- **The main reasons for not billing for the Complex Care Discharge Planning Fee were lack of familiarity with the appropriate billing procedures, the billing process (which was perceived to be onerous by survey respondents) and the perceived inapplicability of the fee to Specialists' roles, practices or situations.**
- **Unexpected outcomes that arose from the Complex Care Discharge Planning Fee included an increase in satisfaction among primary care providers and patient families with receiving written discharge care plans, and improved communication between Specialists and primary care providers.**

Background on the Complex Care Discharge Planning Fee

The objective of the Complex Care Discharge Planning Fee is to support clinical coordination of complicated patients that require community support upon discharge and that are at risk of re-admission. This fee aims to improve the information that is documented when a patient is discharged from hospital to ensure there is proper follow-up and coordination of patient care and management.


COMPLEX CARE DISCHARGE PLANNING INITIATIVE

The fee is payable to the Specialist that is the Most Responsible Physician (MRP) for the majority of the complex patient's in-hospital care and coordinates the hospital discharge for a complex patient with a stay greater than four days. The patient's primary care provider must be notified of the patient's admission by phone, fax, or electronic means within 24 hours, for patients with an estimated length of stay greater than four days.

Among other services, the $75.00 fee premium requires the MRP to write a Discharge Care Plan for the complex patients to ensure that they have a detailed plan following their hospital discharge. More specifically, the written Discharge Care Plan must: [11]

- Be developed in consultation with the health care providers identified in the plan, as necessary. Communication

[11] http://www.sscbc.ca/fees/discharge-care-plan-complex-patients-fee

with the patient's primary health care provider is required.

- Include record of appropriate clinical information, interventions, co-morbidities and safety risks.
- Include re-referral triggers and description of arranged follow-up care.
- Include expectation of symptom progression/remission and patient progress.
- Be included in the patient's medical record.
- Be completed and shared at the time of discharge with the patient and the patient's primary health care provider within 24 hours of discharge.

A sample Discharge Care Plan Template is illustrated on the previous page.

Some claim limits of the Complex Care Discharge Planning Fee include:

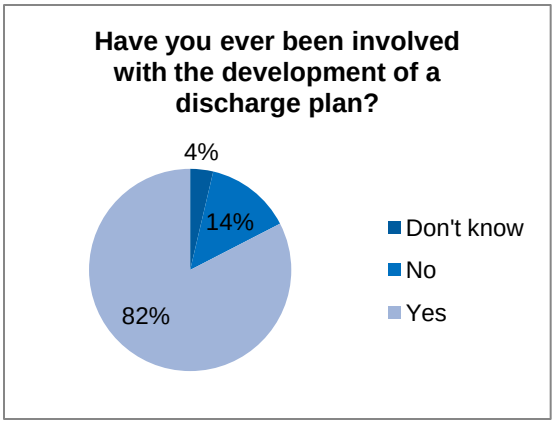
- Payable once per patient per discharge from hospital.
- Claim on the day of discharge.
- Out-of-Office Hours Premiums may not be claimed in addition.
- Cannot be billed simultaneously with salary, sessional, or service contract arrangements.

During the period from April 1, 2013 to October 31, 2013, the fee was utilized by 224 Specialists, who rendered a total of 3,183 services billed under the fee code.[12]

MNP's evaluation findings from 87 "high users" (i.e. Specialists belonging to Psychiatry and Internal Medicine Sections) and 71 "low users" (i.e. Specialists belonging to General Surgery and Cardiology Sections) of the Complex Care Discharge Planning Fee are described below.

Involvement with Complex Care Discharge Planning

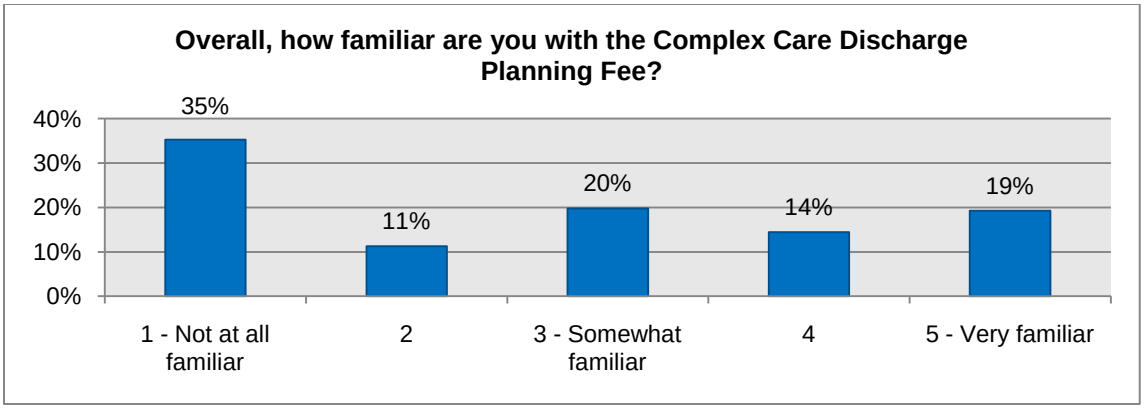
A large majority of survey respondents (82%) had prior experience with developing a discharge plan, while 14% reported no prior involvement.



Based on their experience, respondents described a brief profile of complex patients that require a discharge plan. Most respondents cited particularly complicated cases, patients that require community support upon discharge, and patients that may be at risk of re-admission. Other examples cited included patients discharged from hospital with multiple ongoing medical issues and co-morbidities; elderly patients; cancer patients; and, patients with a history of psychiatric care.

As reported in the following chart, over a third (35%) of respondents were not at all familiar with the fee, and just over half (53%) of respondents were at least somewhat familiar with it.

[12] MSP claims files retrieved from the Doctors of BC.

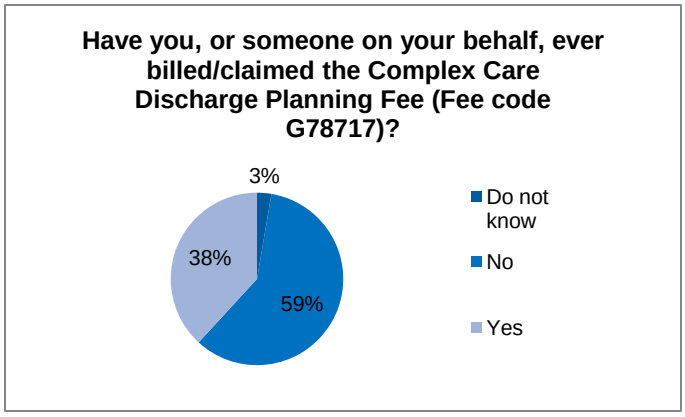


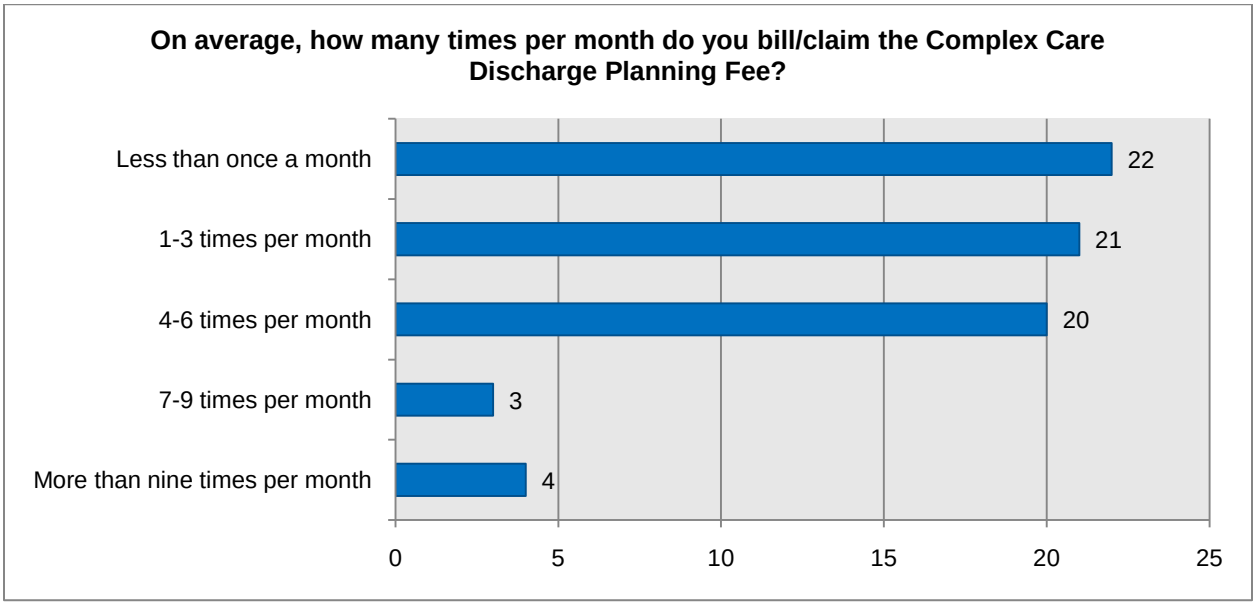
Utilization of the Complex Care Discharge Planning Fee

Utilization of the Fee

Thirty-eight percent of respondents said that they, or someone on their behalf, had billed or claimed the fee.

Of those that claimed the fee, 61% reported billing the fee less than four times per month, 28% billed it four to six times per month, and 10% billed it seven or more times per month.





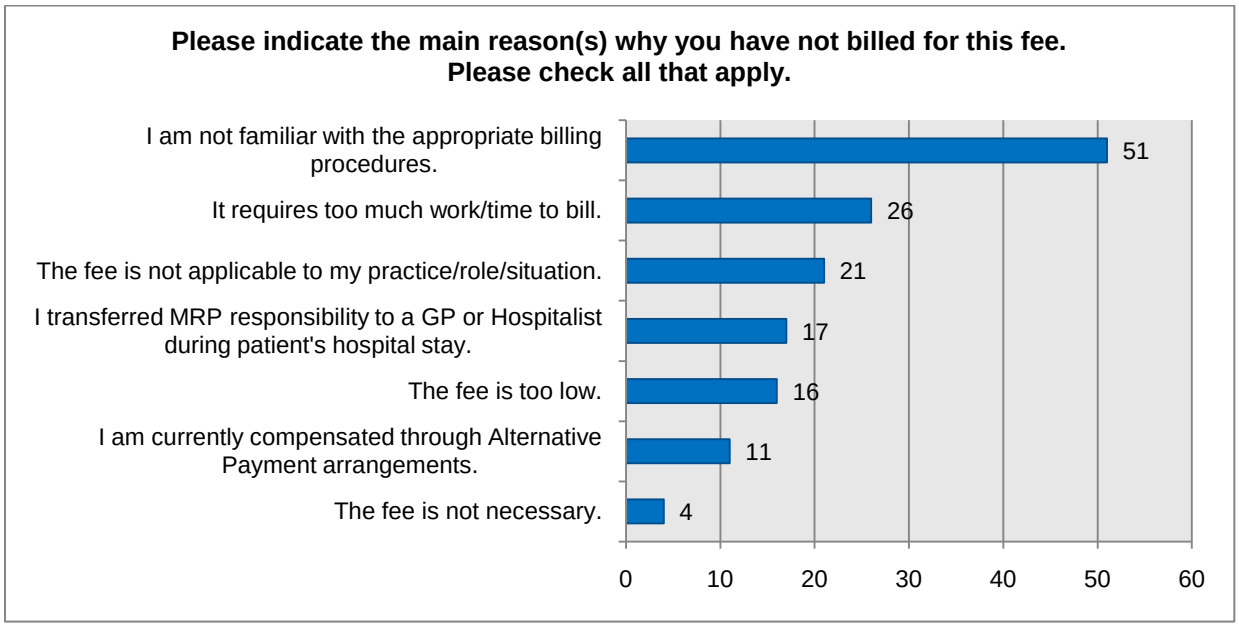
The survey results also demonstrated that the majority (86%) of respondents did not bill the Complex Care Discharge Planning Fee for all complex patients. In providing descriptions of complex patients for whom respondents did not bill the fee, characteristics that were most commonly cited include:

- Patients with a hospital stay of less than four days.
- Patients that do not have a family practitioner in the community.

- Patients that received elective surgery.[13]

Respondents that had not previously claimed/billed the fee cited the following reasons:

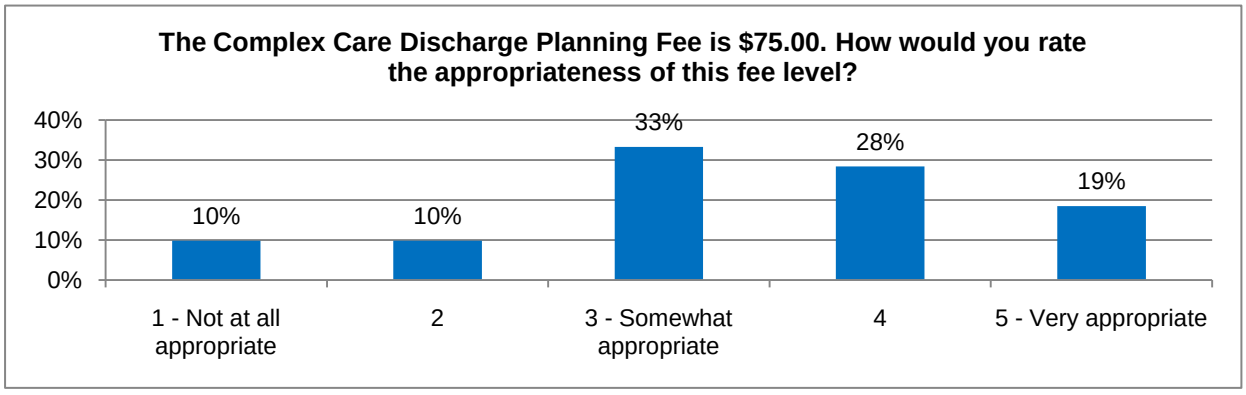
- Lack of familiarity with the appropriate billing procedures.
- The billing process (which was perceived to be onerous by survey respondents).
- The perceived inapplicability of the fee to Specialists' roles, practices or situations.



Respondents that reported having transferred their MRP responsibility to a GP or Hospitalist during their patients' hospital stays were asked to specify whether the MRP was a Specialist, a GP, a hospitalist or another allied health provider. Responses did not produce any common themes, as respondents reported having transferred MRP responsibility to all of the examples listed above. Respondents explained that transferring MRP responsibility was case dependent.

Appropriateness of the Fee Level

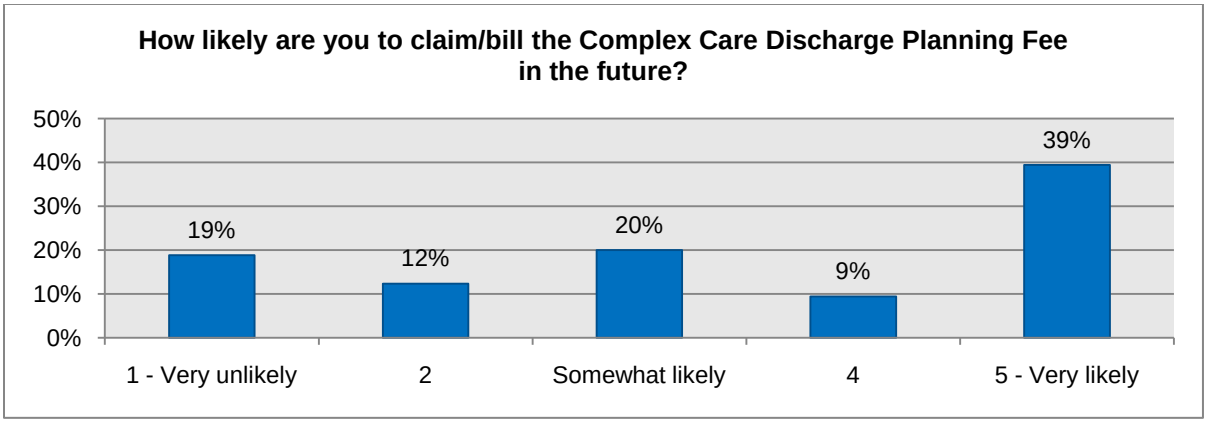
As shown in the following chart, 62% of respondents found the fee level to be "somewhat appropriate" or "appropriate", while 19% found it "very appropriate." Twenty percent found it "not at all" or "not appropriate".



[13] As per the fee guidelines, Specialists cannot claim the Complex Care Discharge Planning fee for patients discharged following elective surgery.

Of the respondents that rated the appropriateness of the fee level, 28% reported that it is too low. Other common statements related to the restrictive requirements of the fee, as well as a suggestion to vary the fee level on a time scale (i.e. the longer it takes to complete the discharge plan, the higher the fee).

Nonetheless, survey results suggest those that have previously billed the Complex Care Discharge Planning Fee are likely to continue billing it.

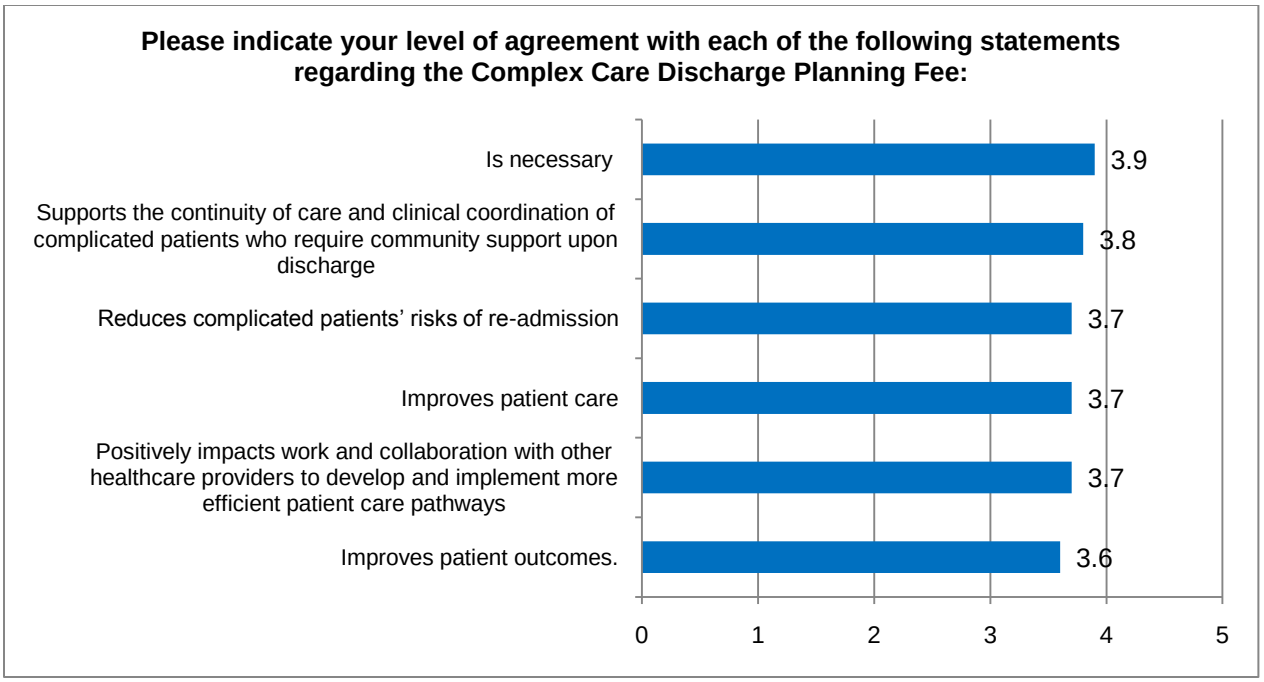


Impacts and Usefulness of the Complex Care Discharge Planning Fee

Respondents rated the extent to which they agree that the fee:

- Positively impacts work and collaboration with other healthcare providers to develop and implement more efficient patient care pathways.
- Supports the continuity of care and clinical coordination of complicated patients that require community support upon discharge.
- Improves patient care.
- Improves patient outcomes.
- Reduces complicated patients' risks of re-admission.
- Is necessary.

Impact was assessed on a scale of 1 to 5, where 1 meant strongly disagree, 3 was neither agree nor disagree and 5 meant strongly agree. The following chart shows respondents' average ratings for each of the listed statements.



Unexpected Results

According to respondents, unexpected outcomes included an increase in satisfaction among primary care providers and patient families with receiving written discharge care plans. Some respondents also credited the fee for helping improve communication between Specialists and primary care providers.

Improvement Opportunities

When asked to articulate recommendations associated with improving the fee, respondents most commonly suggested:

- **Enhancing marketing efforts** to foster greater awareness of the Complex Care Discharge Planning fee amongst physicians.
- **Increasing the fee level.** Respondents felt quite strongly that encouraging physicians to take a more active role in the discharge of their patients is critical; however, most added that uptake will only rise if the fee is increased.
- **Developing standardized electronic templates** across all Health Authorities to reduce the administrative burden.
- **Reducing restrictive criteria associated with the fee** (e.g. length of stay requirement, time restriction associated with notifying the patient's primary care provider).
- **Implementing the fee on a time-scale**, thereby allowing the fee to rise with the amount of time spent developing the discharge care plan. The basis for this recommendation related to concerns that the time and effort required to adequately meet the requirements for claiming the fee are not commensurate with the compensation.

Other suggestions related to improving the efficiency of the overall discharge planning process. Several respondents stated that, besides compensation, an influencing factor associated with physician uptake of the fee is time. These respondents believed that eligible users would utilize the fee if the administration associated with it is made easier and more efficient.

5.3 GROUP MEDICAL VISIT FEES FOR SPECIALISTS

Key Findings

The key final evaluation findings for the Group Medical Visit Fees for Specialists were:

- **The uptake of GMV Fees for Specialists continues to be slow. Total utilization was highest for GMVs that include smaller groups of patients.**
- **The composition of GMVs across interview respondents varied. When describing the key characteristics, elements, and/or supports that make GMVs an effective part of their practice, respondents cited the inclusion of allied health professionals, involvement of other Specialists, improved patient access to care, group dynamics time and cost efficiencies.**
- **Although respondents deemed the GMV fee levels as inappropriate, most reported that they would likely claim the GMV Fees for Specialists in the future.**
- **According to respondents, the GMV Fees for Specialists could be improved by increasing the current fee levels. Respondents also agreed unanimously that patient and physician awareness of GMVs should be improved.**

Background on Group Medical Visit Fees for Specialists

Initially launched for General Practitioners in 2007, the Practice Support Program (PSP) was expanded to include Specialists and their Medical Office Assistants (MOAs) in 2010. PSP modules were tailored to Specialist practices and include Group Medical Visits (GMVs), office efficiency and Advanced Access (patient scheduling).

GMVs are intended for patients with the same or similar chronic care conditions, while respecting appropriate patient privacy. They are aimed at providing an effective way of leveraging existing resources while simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs.

The potential benefits of GMVs are described in the following table.[14]

Potential Benefits of Group Medical Visits	
For Specialists	***For Patients***
• More efficient use of time • Reduces the need to repeat the same information many times • Allows for more time with patients	• Offers peer support • More efficient use of time • Easier and more timely access to care

The GMV fees are billable by Specialists that have completed, or are currently enrolled in, the PSP module for Specialists on Advanced Access and GMVs. Both Specialists and MOAs that attend PSP sessions are compensated. Specialists are compensated at the sessional rate, and are reimbursed for their MOAs' time at a rate of $20 per hour.

The fee structure for GMV Fees for Specialists depends on the number of patients involved. The following table summarizes the fees per patient for every 30 minute period.[15]

[14] http://www.sscbc.ca/fees/group-medical-visits-gmv
[15] Ibid

Group Medical Visits Fees (G78763 - G78781)		
Fee Code	**Number of Patients**	**MSP Fee**
G78763	Three patients	$ 30.81
G78764	Four patients	$ 24.90
G78765	Five patients	$ 21.39
G78766	Six patients	$ 19.03
G78767	Seven patients	$ 17.36
G78768	Eight patients	$ 16.11
G78769	Nine patients	$ 15.12
G78770	Ten patients	$ 14.31
G78771	Eleven patients	$ 12.53
G78772	Twelve patients	$ 11.79
G78773	Thirteen patients	$ 10.92
G78774	Fourteen patients	$ 10.72
G78775	Fifteen patients	$ 10.29
G78776	Sixteen patients	$ 9.98
G78777	Seventeen patients	$ 9.56
G78778	Eighteen patients	$ 9.35
G78779	Nineteen patients	$ 9.02
G78780	Twenty patients	$ 8.80
G78781	Greater than 20 patients	$ 8.49

Some claim requirements and limits of the GMVs fees are:[16]

- A separate claim must be submitted for each patient.
- An active referral is required by a medical practitioner or a health care practitioner for each patient.
- Claim must state start and end times for the service.
- The SSC reserves the right to reduce, suspend or cancel these fee items.
- Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should report "group medical visit" and also identify the other physician.
- Service is not payable with other services, for the same patient, on the same day.
- Not payable to physicians that are employed by, or under contract to, a facility, that would otherwise have provided the service as a requirement of their employment or contract with the facility, or that are working under salary, service contract or sessional arrangement.

During the period from April 1, 2013 to October 31, 2013, Specialists billed a total of 4,540 services under the GMV Fee codes.[17]

MNP's evaluation findings were based on telephone interviews with five Specialists. Four of the five respondents had previously claimed the GMV Fees for Specialists or had completed the PSP module for GMVs. Three of these respondents considered GMVs to be a regular part of their practice, while one utilized GMVs only occasionally.

Utilization of, and Familiarity With, the Group Medical Visits Fees

The following table shows total utilization of GMV Fees by Section over the first two fiscal years in which the fees were implemented. From fiscal year 2011/12 to fiscal year 2012/13, Specialists from Psychiatry and Internal Medicine accounted for more than 96.6% (1,238 out of 1,281 sessions) of the total share of claimed GMV sessions. Of the six psychiatrists that claimed the fee, three claimed 93% of the services, or 58% of all sessions claimed. In comparison, of the four internists that claimed 432 sessions over the two

[16] http://www.sscbc.ca/fees/group-medical-visits-gmv
[17] MSP claims files retrieved from the Doctors of BC.

years, one claimed 89% of these services, or 30% of all sessions claimed. In summary, four Specialists over the two-year period accounted for over 88% of all GMVs claimed.

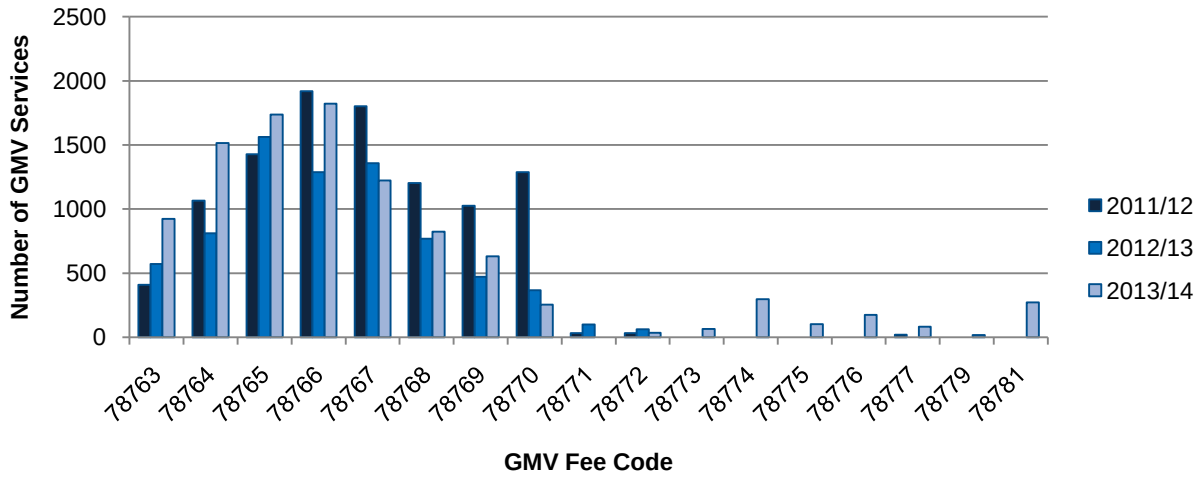
Utilization of GMV Fees by Section in Fiscal Year 2011/12 and 2012/13

Section	Number of Physicians	Number of GMV Sessions Claimed	Share of Claimed Sessions
Psychiatry	6	806	62.9%
Internal Medicine	4	432	33.7%
Pediatrics	2	10	0.8%
Respirology	3	9	0.7%
Neurology	1	8	0.6%
Cardiology	1	8	0.6%
Anesthesiology	1	4	0.3%
Ophthalmology	1	2	0.2%
Endocrinology	1	2	0.2%
Total	**20**	**1,281**	**100.0%**

Source: Retrieved from Doctors of BC.

The following chart shows the number of GMV services[18] billed from fiscal year 2011/12 to fiscal year 2013/14[19]. As can be seen in the chart, total utilization was highest for GMVs that include smaller groups of patients. Overall, utilization increased in fiscal year 2013/14 (9,987 services) relative to fiscal year 2012/13 (7,363 services); however, it was still below the number of services provided in fiscal year 2011/12 (10,228 services).

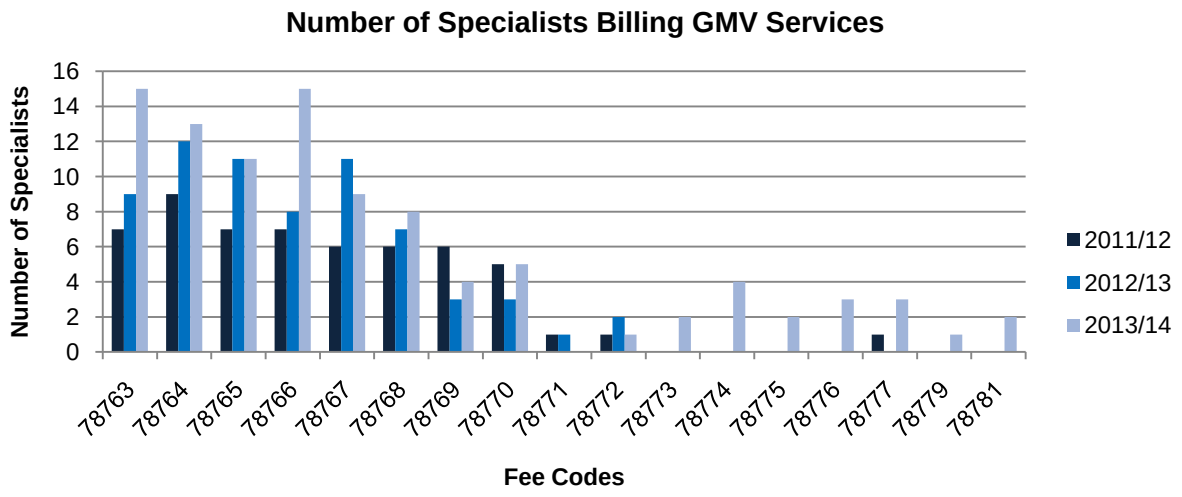
Number of GMV Sessions by Fiscal Year (2011/12 to 2013/14)



[18] As GMV Fees are billed in thirty minutes increments, MNP has used "GMV services" to describe each thirty minute GMV Fee claimed in a fiscal year rather than the number of sessions (e.g. one ninety minute session would be considered three services (per person)).

[19] For the FY 2011/12 to 2013/14, the data are compiled on a date-of-service basis and include claims paid up to June 30th for each FY.

The following chart shows the number of Specialists that billed GMV services from fiscal year 2011/12 to fiscal year 2013/14[20]. As can be seen in the chart, the number of Specialists that billed GMV fee codes was highest for smaller groups of patients.



As part of the evaluation telephone interviews were conducted with four Specialists that had previously claimed the GMV fees, and with one Specialist that had completed the PSP module for GMVs. MNP's summary of interview findings is presented below.

Familiarity with GMVs

Most respondents described learning of GMVs through word-of-mouth or colleague referral. Two Specialists were exposed to GMVs while visiting the Cleveland Clinic[21] in Cleveland, Ohio.

In comparing these results with the findings of the Mid-term Evaluation of the SSC, word-of-mouth and colleague referrals continued to be the most common methods through which Specialists learned of GMVs.

Utilization of GMVs

Resondents' utilization of GMVs varied, ranging from three to four times per year to upwards of 150 times per year.

Composition of GMVs

Respondents were asked to describe the key characteristics, elements and/or supports that make GMVs an effective part of their practice. Respondents most commonly cited:

- **Inclusion of allied health professionals.** All respondents involved other allied health professionals (e.g. dieticians, pharmacists, physiotherapists, nurses) in GMVs. When asked about the involvement of other allied health professionals, one respondent provided an example to illustrate the added value associated with including an allied health professional in their practice. In the example given, Registered Nurses (RNs), compensated by their Health Authority through the MSP, facilitated an educational class and performed the initial patient assessment prior to a GMV. According to the respondent, the participation of the RNs enhanced patient access to care, quality of care and

[20] For the FY 2011/12 to 2013/14, the data are compiled on a date-of-service basis and include claims paid up to June 30th for each FY.
[21] In March 2014, SSC staff met with stakeholders from the Cleveland Clinic (CC) to discuss the process the Clinic uses to establish GMVs with a particular physician. At that CC, once a physician demonstrates an interest in implementing GMVs, CC staff facilitates a meeting with the physician to determine how the service would best fit within his or her practice. (Retrieved from Doctors of BC, "Shared Medical Appointments – Key Lessons Learned".)
More information on the CC and its GMVs structure can be found online: http://my.clevelandclinic.org/patients-visitors/prepare-appointment/shared-medical-appointments.aspx

efficiency, as it enabled patients to consult with more than just their Specialist (i.e. access to knowledge). Respondents also encouraged greater collaboration between Specialists and allied health professionals (e.g. nutritionists, life coaches, social workers, etc.).

- **Involvement of other Specialists.** Three respondents, that actively use GMVs as part of their practice, also acknowledged the involvement of other Specialists during GMVs. One respondent noted that, in some cases, a resident physician would observe the GMV and help by transcribing notes for medical records while the discussion was being facilitated. The involvement of another Specialist, according to one respondent, provided validation through a second opinion, as well as the peer review associated with having a colleague oversee their work.
- **Improved patient access to care.** On improving patient access to care, one respondent stated that allowing physicians to see more patients at one time reduces repetition while still allowing an opportunity for individual patient follow up.
- **Group dynamics.** Several respondents noted that patients developed a preference for the group dynamic because it enabled them to hear from other patients with the same or similar chronic care conditions. One respondent commented that the group dynamic allowed patients "to develop a level of camaraderie with each other which helps them to engage in lifestyle improvement." Respondents stressed that GMVs improved patients' knowledge of their chronic care conditions.
- **Time and cost efficiencies.** Respondents reported that GMVs enable Specialists to address the mutual needs of several patients simultaneously, thus increasing time and cost efficiencies when compared to traditional individual consultations. One respondent, that utilizes RNs to facilitate educational classes and to perform initial patient assessments prior to GMVs, reported that the use of allied health professionals is also time and cost-effective (e.g. RNs perform initial assessment rather than the Specialist, which also means that compensation for the initial assessment is paid at the RN rate rather than the Specialist rate).
- **Referral base.** Some respondents cited that the success of GMVs is dependent on growing awareness of the service, as well as the establishment of a good referral base with General Practitioners.

Average GMV sizes varied across respondents and ranged from four to seven patients (the most common group size being four to five patients). Respondents cited treating patients with paediatric asthma, cardiac conditions (e.g. engina, open heart surgery, valve replacement), and mood disorders (e.g. depression, manic depression, anxiety). All respondents cited that their current office or clinic offered sufficient space to accommodate both small and large groups. Three of the five respondents facilitated GMVs in either hospital or community-based clinics that enabled them to accommodate group sizes of four to seven patients.[22]

Respondents stated that it is common practice to follow up with patients on a one-on-one basis following a GMV. However, respondents added that performing a one-on-one follow-up is situational and dependent on the severity of a patient's condition. All respondents also stated that MOA support is available to them; however, MOAs are not solely dedicated to coordinating GMVs but rather serve as a general support resource. Two respondents stated that their MOA also helps patients to understand and abide by their program's rules and procedures.

[22] It should be noted that, as the majority of our sample of Specialists operate their practice in larger clinics, our findings may not be reflective of Specialists that provide GMVs in other types of office settings.

Types of Patient Conditions, Programs/Services and Sections Deemed as Appropriate for GMVs

Respondents believed the following types of patient conditions, programs and/or services to be suitable for GMVs:

- General paediatrics
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Hypertension
- Pre-operative surgical reviews
- General patient education
- Behavioural disorders such as Attention Deficit Hyperactivity Disorder (ADHD)
- Constipation
- Arthritis management
- Pregnancy
- Coronary artery disease
- Dietary support

Respondents suggested the following Sections to be targeted for GMVs:

- Cardiology
- Respirology
- Paediatrics
- Psychiatry
- Obstetrics and gynaecology
- Orthopaedics

Satisfaction with the Group Medical Visits Fees

The majority of respondents found the GMV fee levels to be inappropriate. Respondents' average rating for the fee levels (on a scale of 1 to 5, where 1 is not at all appropriate, 3 is somewhat appropriate and 5 is very appropriate) was 2.0. Factors contributing to respondents' dissatisfaction with the GMV fee levels included:

- GMV fees are perceived to be too low to encourage further uptake among Specialists.
- GMV fees are not payable with other services for the same patient, on the same day.
- GMV fees do not compensate Specialists for non-patients that are attending GMVs (e.g. legal guardians accompanying patients below the age of 18).

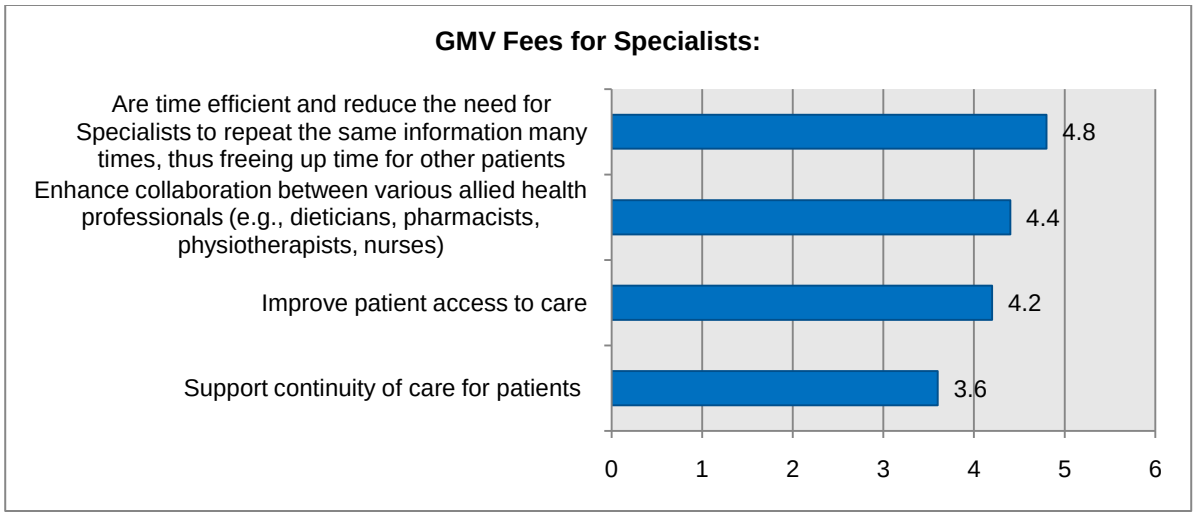
Nonetheless, respondents were likely to claim the GMV fees again in the future. When asked to rate the likelihood of claiming the GMV fees in the future, respondents' average rating was 4.2. Two respondents stated that GMVs are an integral service provided by their clinics. Another respondent stated improved access to care and systemic efficiencies as the main reasons for continuing GMVs as a component of his/her practice.

Impacts of the Group Medical Visits Fees

Respondents rated their level of agreement with each of the following statements:

- The fees are time efficient and reduce the need for Specialists to repeat the same information many times, thus freeing up time for other patients.
- The fees improve patient access to care.
- The fee support continuity of care for patients.
- The fees enhance collaboration between various allied health professionals (e.g. dieticians, pharmacists, physiotherapists, nurses).

Agreement was assessed on a scale of 1 to 5, where 1 meant strongly disagree, 3 meant neither agree nor disagree, and 5 meant strongly agree. As reported in the following chart, respondents agreed that the fees are time efficient, enhance collaboration between allied health professionals and improve patient access to care.



Unexpected Results

Respondents cited a number of positive, unexpected outcomes associated with GMVs. Several respondents noted that results were better than expected, as patients developed a preference for the group dynamic because it enabled them to hear from other patients with the same or similar chronic care conditions. Respondents also noted that GMVs were received better than expected amongst patients and their families.

Improvement Opportunities

Respondents provided a number of suggestions regarding opportunities for improvement with GMVs. The most common suggestion was that an increase in the fee amount per patient would likely improve uptake of the fee codes. Respondents also agreed unanimously that patient and physician awareness of GMVs should be improved. One respondent stated that Specialists would be more likely to offer GMVs in their practice if their patients or colleagues were to approach them with positive recommendations based on their previous experience with GMVs.

Other improvement suggestions by respondents included:

- **Adding an addendum to the GMV fees to allow Specialists to offer GMVs for education and knowledge transfer.** A respondent, that conducts GMVs with patients with paediatric asthma, reported that patients below the age of 18 require the accompaniment of parents or legal guardians, which is not accounted for by the GMV fee codes. The respondent suggested that, for conditions that require a significant educational component (e.g. paediatric asthma, diabetes, COPD, hypertension, etc.), Specialists should be enabled to claim the GMV fees for the facilitation of in-depth group consultations and educational sessions for patients and their parents or legal guardians.
- **Adding an addendum to the GMV fees to allow remuneration for one-on-one patient follow-ups.** Respondents also noted that many complex patients require consistent follow-up care. Thus, it was suggested that the addition of an addendum to the GMV fees to provide remuneration for individual patient follow-ups could improve utilization of the fees.
- **Adding resources to enable greater collaboration with allied health professionals.** Respondents stated that the addition of resources would improve Specialists' ability to collaborate with allied health professionals (e.g. respiratory therapists, RNs, nutritionists).

The following recommendation was consistent across both the mid-term and final evaluation reports:

- The fee per patient associated with the GMV should be increased to incentivize Specialists.

5.4 LABOUR MARKET ADJUSTMENT INITIATIVE

Key Findings

The key final evaluation findings for the Labour Market Adjustment (LMA) initiative were:

- **Interviews with Section Heads and Economic Leads of the Sections that obtained funding through the LMA initiative suggest that the initiative has made progress towards reducing pressures associated with recruitment and retention across all participating Sections.**
- **Respondents were generally satisfied with the overall process implemented by the SSC to address labour market adjustments as well as with the review panel process that was implemented.**
- **According to respondents, the fees created as a result of the LMA initiative have incentivized Specialists to collaborate with allied health professionals, to implement new techniques and to utilize telephone or virtual follow-ups as part of their patient consults.**
- **Respondents noted that a lack of initial understanding of the implications and consequences of under or over-utilization of fee codes implemented through the LMA initiative affected Section proposals.**
- **Respondents stated that the LMA initiative could be improved further by ensuring the availability of ongoing funding as the utilization of new fee codes rises.**

Background on the Labour Market Adjustment Initiative

During the negotiation of the 2012 PMA, the BC Government and the Doctors of BC agreed to set aside a fund of $20 million to address recruitment and retention issues affecting Specialists in BC.[23] The fund was composed of $10 million of new funding and $10 million of pre-existing SSC funding.[24] The SSC dedicated $10 million towards making labour market adjustments, where required, to recruit and/or retain Specialists in BC. A LMA Advisory Group was established by the SSC to allocate the $10 million. The LMA Advisory Group was tasked to review information, including reviewing and assessing submissions from Specialist Sections, on Specialist recruitment and retention issues and inter/intra-provincial disparities.[25] To do this, the Advisory Group consulted with relevant stakeholders including the Society of Specialists and Surgeons, the Society of General Practitioners, Health Authorities, the Ministry of Health Services and the Doctors of BC.[26]

The allocation of funding among Sections was made by an independent party, Eric J. Harris, Q.C. After considering Sections' submissions as well as data reviewed and analyses conducted, Mr. Harris allocated $10,031,910 among nine Sections.

Section	Section Allocation
	2012/13, including 0.5% increment
02 – Neurology	$1,005,000
05 – Obstetrics & Gynaecology	$1,021,080
15 – Community and Rural Internal Medicine	$2,613,000
18 – Anaesthesia	$1,407,000
24 – Geriatric Medicine	$301,500

[23] Re: 2012 Specialists Recruitment and Retention Fund Arbitration. April 7, 2013. Eric J. Harris, Q.C Arbitrator
[24] Ibid
[25] Specialist Services Committee Labour Market Adjustment (LMA) Allocation Framework. Final – January 26, 2010.
[26] Ibid

Section	Section Allocation
	2012/13, including 0.5% increment
44 – Rheumatology	$1,708,500
49 – Respirology	$502,500
51 – Endocrinology	$934,650
67 – Infectious Diseases	$538,680
Grand Total	**$10,031,910**

Source: MSP Claims Files retrieved from the Doctors of BC, FY 2012/13.

The allocations were then used by each Section to implement LMA Fee Items with the aim of addressing labour market adjustments linked to recruitment and retention pressures. A total of 43 new fee codes were created and implemented during the summer of 2011. In most instances, the LMA fee codes are "add-ons", billed in addition to existing fee codes (such as a modifier for patients over a certain age). In some cases, however, the fee codes are replacements for existing fee codes which are billed instead of an existing fee code.[27] The specific fee codes that were created and implemented through LMA funding are summarized in **Appendix B**.

After a 12-month monitoring period following the first three months of implementation, it was determined that two Sections had exceeded their allocated funding amounts, while the other seven Sections came within or under budget. The following table describes the discrepancies in allocations and utilization among all the Sections.

Section	LMA Utilization Summary By Section			
	Section Allocation 2012/13, including 0.5% increment	Under/Over the Allocated Amount	Difference (Net Expenditure-Allocation)	Percentage (%) difference from Allocated Amount
02 – Neurology	$1,005,000	Under	($389,806)	-39%
05 – Obstetrics & Gynaecology	$1,021,080	Under	($13,875)	-1.4%
15 – Community and Rural Internal Medicine	$2,613,000	Over	$1,529,435	58.5%
18 – Anaesthesia	$1,407,000	Under	($54,618)	-3.9%
24 – Geriatric Medicine	$301,500	Under	($199,966)	-66.3%
44 – Rheumatology	$1,708,500	Under	($1,086,755)	-63.6%
49 – Respirology	$502,500	Under	($162,775)	-32.4%
51 – Endocrinology	$934,650	Under	($311,083)	-33.3%
67 – Infectious Diseases	$538,680	Over	$150,261	27.9%
Grand Total	**$10,031,910**			

Source: MSP Claims Files retrieved from the Doctors of BC, FY 2012/13.

Notes:

(1) Section is within budget during the monitoring period; Proposal- the SSC should fund any additional growth in utilization
(2) Proposal - to work with Section to reduce some or all fees so that expenditures during the monitoring period are within budget; any further increase in utilization (outside the monitoring period) to be funded by the SSC
(3) Sections sent proposals to use some of their unspent funds to change existing LMA fees; Ministry has approved proposals of Rheumatology, Respirology, and Endocrinology. For details, refer to table 2

[27] Labour Market Adjustment Summary Document. August 2012

To adjust the amounts allocated to each Section and address discrepancies, The Doctors of BC, Ministry of Health and SSC agreed on the following courses of action on the LMA fees:[28]

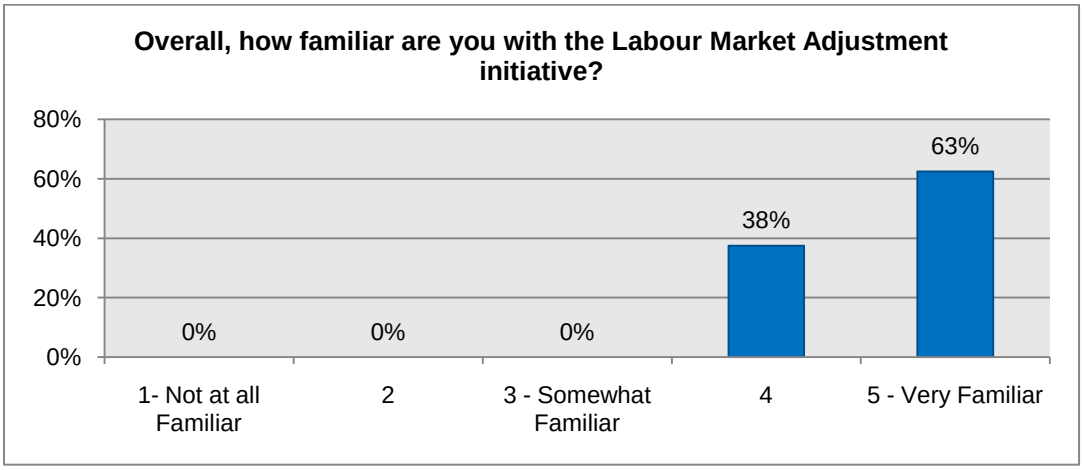
- For Sections that are over budget (Infectious Diseases and Internal Medicine), some or all of their fees were reduced so that expenditures during the monitoring period are within budget, and any further increase in utilization (outside the monitoring period) will be funded by the SSC.
- For Sections that are below their budget (Rheumatology, Respirology, Endocrinology, and Geriatric Medicine), various changes to specific fee billing rules or rates were made. Some of the unspent funds were reallocated within each of the Sections' own budget to adjust their existing LMA fees. These changes were proposed by the Sections and agreed to by the Doctors of BC, The Ministry of Health and the SSC.

While no additional funding is required at this time, a future increase to the annual ongoing funding for the LMA initiative will likely be required to support natural utilization growth outside the monitoring period. Any natural growth in utilization (outside the monitoring period) will be funded by the SSC.

MNP's evaluation findings from telephone interviews with eight Section Heads and two Economic Leads[29] of the Sections that obtained funding through the LMA initiative are described below.

Familiarity with the LMA initiative

When asked how familiar they were with the LMA initiative, most respondents identified themselves as being familiar or very familiar with the initiative. Most respondents reported being involved in the preparation of their Section's proposal for LMA funding.

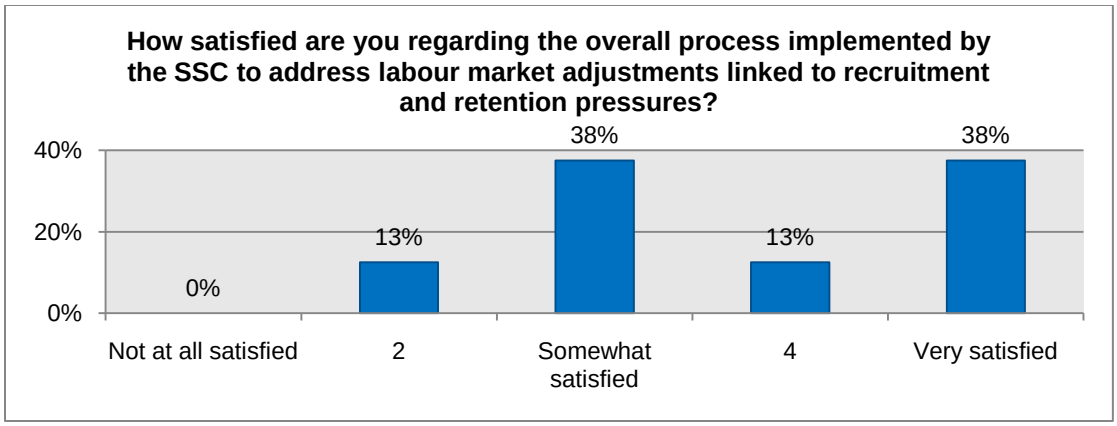


Satisfaction with the Process

All Section Heads and Economic Leads agreed that the LMA initiative was an appropriate response to address labour market adjustments linked to recruitment and retention pressures, and that it had contributed to the reduction of such pressures.

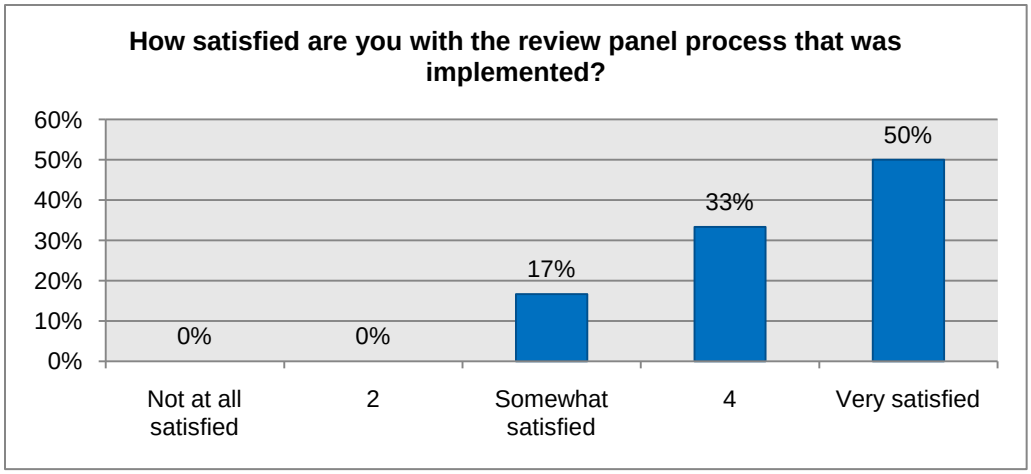
When asked to rate their satisfaction with the overall process implemented by the SSC (including the readjustments made post-LMA funding, as some Sections had over/under spent their allocations), respondents provided an average rating of 3.8.

[28] Specialist Services Committee Decision/Discussion Briefing Document. November 14, 2013.
[29] Economic leads for the following Sections were interviewed: Neurology, Community and Rural Internal Medicine, Infectious Diseases, Geriatric Medicine, Rheumatology, Respirology, Obstetrics and Gynaecology, and Endocrinology.



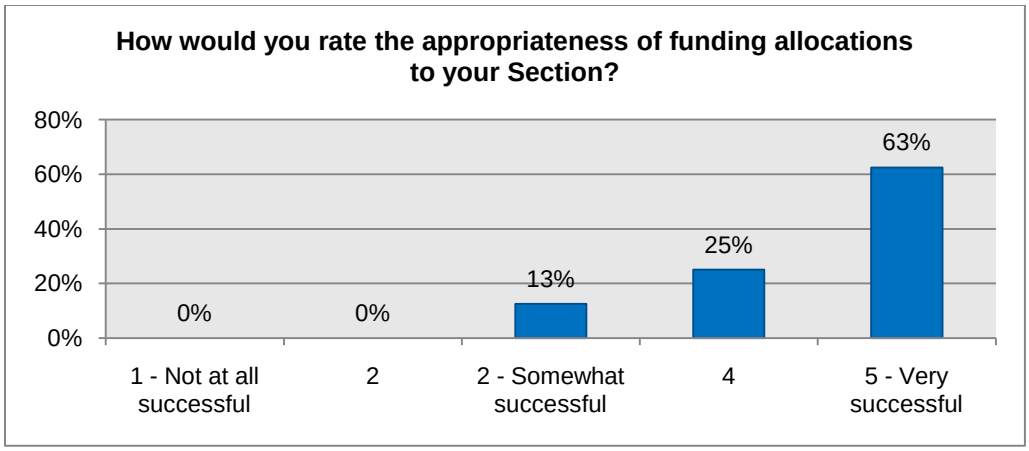
Feedback provided by respondents was generally positive; however, several Section Heads noted the difficulty associated with forecasting the utilization of fee codes.

When asked to rate their satisfaction related to the review panel process that was implemented[30], respondents provided an average rating of 4.3. It should be noted that two respondents were unaware of the panel review process and were thus unable to provide a rating. Respondents that were familiar with the process described it as transparent and objective.



Respondents were also asked to rate the appropriateness of funding allocations to their Section. As reported in the following chart, respondents generally deemed the funding allocations to their respective Sections as appropriate.

[30] An independent panel was created in June 2010 to review submissions from sections interested in receiving funds for new fees as part of the labour market exercise.



All respondents were aware of the utilization of new fees implemented through the labour market adjustment process (i.e. what Sections' new fees were over and/or underutilized). When asked to comment on what (if any) changes they would make, in retrospect, regarding how funding was applied to their Section, respondents most commonly identified the following:

- Higher utilization of fee codes associated with minimally invasive and/or newer techniques. In certain Sections, Specialists have increased their utilization of minimally invasive fees as a result of the increase in the fee codes
- Fewer fee codes to maximize budget for the most successful fee codes
- Greater accuracy of initial funding requests to align LMA funding with actual utilization

When asked to comment on what (if any) changes they would make, in retrospect, regarding how adjustments were made to their Section, respondents most commonly reported eliminating fee codes with limited uptake so as to maximize the total budget available for the most highly utilized fee codes. Some respondents also noted that it would have been beneficial to receive more upfront information on the consequences and implications of under and/or over-utilization of fee codes implemented as a result of the LMA Funding initiative.

Effects of Labour Market Adjustments on Specialist Recruitment and Retention

Types of Recruitment and Retention Pressures Identified

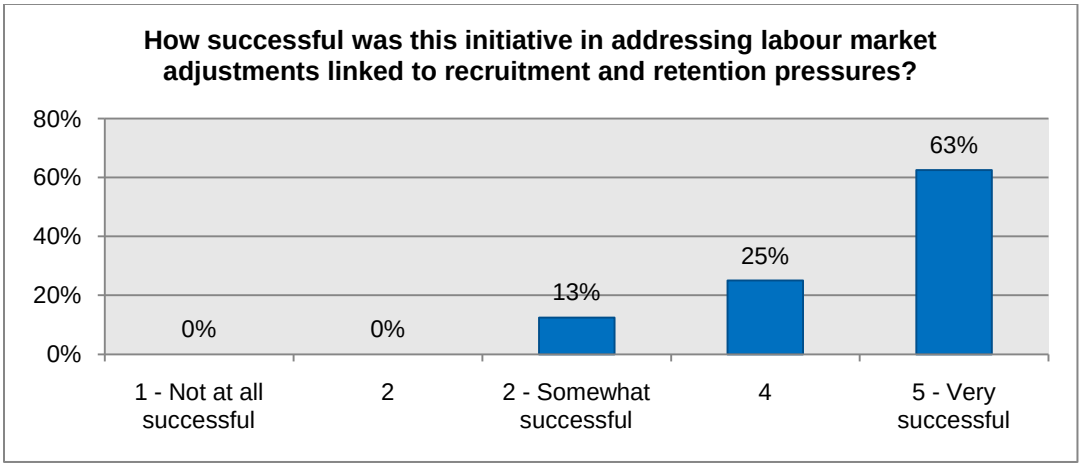
The following table summarizes the recruitment and retention pressures noted in the proposals made by the nine Sections that received funding under the LMA initiative.

Section	Types of Recruitment and Retention Pressures Identified in Sections' LMA Funding Proposals
02 – Neurology	• Rising demand for neurologic services has not been addressed with commensurate staffing relative to other provinces. • BC is not recruiting neurologists at the national average rate of recruitment and also lags behind Alberta and Ontario.
05 – Obstetrics & Gynaecology	• A lack of Obstetrics and Gynaecology (OB/GYN) Specialists has created concern with regard to patient access to care. • The proposal suggests that LMA funding be used to ensure BC communities are equipped with appropriate expertise and manpower in OB/GYN.
15 – Community and Rural Internal Medicine	• Income disparity has largely contributed to making Internal

Section	Types of Recruitment and Retention Pressures Identified in Sections' LMA Funding Proposals
	Medicine understaffed across BC. • Previous attempts to address relative fee code gaps have failed, as such recruitment and retention issues continue.
18 – Anaesthesia	• Compensation of Anaesthesiologists in BC is below that of Anaesthesiologists based in Ontario and Alberta. • As BC's population continues to age, and pressure mounts to reduce surgical waitlists, BC must compete with other provinces to recruit and retain Anaesthesiologists. • Given its low ratio of Anaesthesiology resident trainees relative to the provincial workforce, BC must recruit from out of province.
24 – Geriatric Medicine	• Demand for Geriatric Medicine Specialists (GMS) is exceeding supply. • The Geriatric Medicine proposal states that funding arrangements for GMS are ineffective and inadequate. Most BC GMS receive blended compensation through Fee for Service (FFS) and Alternative Payment Plan (APP) rather than complete FFS, as is the case in other provinces.
44 – Rheumatology	• Demand for Rheumatologists is well below supply. • Despite requiring the same amount of post-graduate study time (5 years), Rheumatologists are not remunerated at the same level as most other specialties, thus limiting incentivisation for students to pursue a career in the specialty.
49 – Respirology	• A shift from Respiratory Medicine (RM) to Critical Care Medicine (CCM) resulted in fewer Specialists practicing RM. • The transition from RM to CCM is incentivized by the attractive CCM fees (i.e. CCM fee codes are higher relative to RM's).
51 – Endocrinology	• Compensation of Endocrinologists is below that which is offered in Ontario and Alberta. • Income disparity is discouraging medical students from choosing a career in Endocrinology in BC. • The proposal also added that a shortage of Endocrinologists is leading to suboptimal care of patients with endocrine conditions.
67 – Infectious Diseases	• The Infectious Diseases proposal suggests that personnel shortages have been associated with lower fee codes relative to other specialties (e.g. General Medicine) which, in some cases, require less training. • This proposal aimed to eliminate that gap in fee codes between Infectious Diseases and General Medicine.

Satisfaction With, and Perceived Success of, the LMA Initiative

MNP's interview findings suggest that Sections are generally satisfied with the effects of the LMA initiative on Specialist recruitment and retention. When asked to rate how successful the LMA initiative was with addressing labour market adjustments linked to recruitment and retention pressures (i.e. whether the allocations established new fees or initiatives that help support the delivery of physician services), respondents provided an average rating of 4.5.



Respondents stated that the LMA initiative has improved their Sections' ability to attract and retain Specialists, as the new fees helped to reduce income disparities across Sections and to encourage Specialists to utilize the new fee codes.

Success and Constraining Factors

Section Heads and Economic Leads cited the following factors as making the LMA initiative a positive experience:

- The LMA initiative provided each Section with the same timeline, basic information, and opportunity to access the Doctors of BC resources.
- The LMA initiative provided an opportunity to reconcile gaps in fee codes across Sections (i.e. income disparity).
- Funding allocated as a result of the initiative helped Sections retain Specialists in community settings and to reduce remuneration disparity.

In contrast, the most commonly cited factors that were perceived to have constrained the LMA initiative were:

- Differences in the resources available to Sections resulted in disparities in the quality of proposals submitted.
- Total funding allocations were perceived to be inadequate by some Sections.
- A lack of understanding of the implications and consequences of under or over-utilization impacted Section proposals.

Other Impacts and Effects of the Labour Market Adjustment Funding Initiative

The findings from MNP's interviews with Section Heads and Economic Leads suggest that the LMA initiative had positive impacts on all nine Sections. Respondents cited the following impacts and effects that have occurred as a result of the initiative:

- The LMA initiative contributed to reducing pressures associated with recruitment and retention across all participating Sections.

- The LMA initiative incentivized Specialists to collaborate with allied health professionals, advance their practice with new techniques, and, when appropriate, to utilize technology as part of their consults.
- Certain fee codes that enable Specialists to work from home have allowed for internal recruitment, as it allowed them to consult with patients while working on a reduced schedule (e.g. maternity/paternity leave).
- Certain fee codes advanced physician practices (e.g. engaging allied health professionals, technology-supported consultations, etc.).
- The LMA initiative improved patient access to care through the use of new fee codes (e.g. multi-disciplinary fee codes, virtual patient consult codes).
- The LMA initiative provided a mechanism that allowed Sections to establish more competitive compensation, and to compete with other provinces in the recruitment of Specialists.

Fees Deemed Most Successful and Applicable for Other Sections

Respondents were also asked which of their new fees they believe have been most successful for their Sections and could support other types of Sections. The most commonly reported fees include:

- **Conference Fee Codes**. These fee codes are paid in fifteen minute intervals and, according to respondents, enable better care planning for complex patients.
- **Complex Care Fee Codes.** These fee codes were allocated to patients with needs that require longer than average consultations.
- **Prolonged Surgery Fee Codes**. These fee codes allow Specialists to code their time in fifteen minute intervals for surgeries that run over the allocated timeframe.
- **Virtual Follow Up Fee Codes.** These fee codes allow Specialists to facilitate patient follow ups via teleconference or internet-based communication.
- **Multi-disciplinary Fee Codes.** These fee codes encourage Specialists to collaborate with allied health professional in the provision of quality patient care.

Improvement Opportunities

When asked to provide recommendations associated with improving the LMA initiative, respondents suggested:

- **Ensuring that ongoing funding is available as the utilization of new fee codes rises** (i.e. for successful codes, there is a need for funding to be commensurate with demand). Several respondents highlighted their concerns with placing utilization caps on successful fee codes, as it inhibits their long term success.
- **Establishing a more effective mechanism to estimate fee code utilization** in advance of future implementations.
- **Improving monitoring mechanisms and tools** to avoid overlap of fee codes, review utilization and analyze whether fees are contributing to improved patient care.
- **Providing Sections with more up-front information** on the consequences and implications of under and/or over-utilization of fee codes implemented as a result of the initiative.

Respondents were also asked if there are any other specific fees that would help address recruitment and retention pressures, should additional funding for LMAs be made available in the future. Most respondents agreed that the sustainability of previously developed fee codes is of greater importance than the establishment of additional fee codes. A few respondents, however, suggested that, should additional funding for LMAs be made available, new fee codes could be created to incentivize Specialists to practice in BC's isolated or rural communities.

5.5 HEALTH AUTHORITY REDESIGN FUNDING INITIATIVE

Key Findings

The key final evaluation findings for the Health Authority Redesign Funding initiative were:

- **The majority of Specialists interviewed learned about the initiative through their respective Health Authority. Health Authority Representatives interviewed reported the most common means of engaging Specialists was by communicating that their time is compensated. The compensation of physicians through sessional payments defrays some of the opportunity cost of putting aside clinical hours to participate in the initiative.**
- **Respondents were engaged in a variety of activities, ranging from e-Health program development and promotion to participation in cross-disciplinary care. Specialists interviewed reported that they were very likely to participate in the initiative again.**
- **Findings suggest that the initiative contributed to increased interactions and collaboration between Specialists and Health Authorities.**
- **Respondents recommended multi-year or renewable funding, as well as increased funding, to ensure the financial sustainability of projects.**

Background on the Health Authority Redesign Funding Initiative

The Health Authorities' System Redesign initiative began in May 2010. The objective of the initiative is to support and encourage participation in system redesign initiatives to improve the delivery of Specialist services.[31]

Specialists play an important role in influencing, developing and implementing redesign plans. Therefore, the SSC allocated funding to compensate Specialists for participation in health system redesign initiatives led by the Health Authorities. This is beyond hospital administrative duties that Specialists may already be responsible and compensated for.[32]

If their involvement is required for health system redesign initiatives, Specialists are contacted directly by Health Authorities. Funding requests are then submitted by Health Authorities to the SSC for consideration and approval. Specialists are paid by the Health Authority at sessional rates.[33]

MNP's evaluation findings from telephone interviews with nine Health Authority Representatives and eight Specialists involved in the Health Authority Redesign Funding initiative are described below.

Involvement with the Health Authority Redesign Funding Initiative

Communication and Engagement Methods

Most Specialists interviewed learned of the initiative through their respective Health Authority. Two respondents were already working on a redesign initiative when the Health Authority informed them of the initiative. One respondent heard about the initiative through e-news.

Health Authority representatives interviewed reported that the most common processes they employ to engage Specialists with the initiative include:

- **Compensation.** Compensation was the most commonly reported strategy for engaging Specialists. Respondents stated that Specialists want to assist in Health Authority Redesign projects but that involvement in such initiatives is particularly difficult for fee-for-service physicians. Thus, the compensation of physicians through sessional payments defrays some of the opportunity cost of putting aside clinical work to participate in the initiative. One respondent also cited that remunerating Specialists helps to convey that Health Authorities value physicians' input.

[31] http://www.sscbc.ca/partnership-work/health-authority-redesign
[32] Ibid
[33] Ibid

- **Management level engagement.** Two Health Authorities have implemented a system where they assign a physician and an administration professional to take leadership of a Health Authority Redesign project. The assigned physician then identifies other colleagues suited for a particular project.
- **Clear communication of project requirements, objectives and expectations.** Health Authority representatives stressed the need to avoid any miscommunication with Specialists, and to ensure that all stakeholders are aware of, and in mutual agreement with, each others' roles and expectations at the start of a project. Some Health Authority representatives also reported that it is important to have clear communication about project requirements, objectives and expectations at the beginning of a project.
- **Employing a grassroots approach.** Some Health Authority representatives started processes where they ask Specialists to propose redesign projects instead of the Health Authority determining redesign initiatives to pursue. According to the respondents, this approach assists Health Authorities with completing funding applications for projects deemed feasible and appropriate by Specialists.
- **Off-hours scheduling.** One Health Authority Representative also reported that meeting times outside of typical clinical hours also help accommodate Specialists.

Engagement strategies are consistent with MNP's mid-term evaluation findings, but with a greater focus on compensation. In both the mid-term and outcome evaluation, Health Authority Representatives often first spoke with Specialists about their visions and objectives of the project, and then notified them about the level of reimbursement.

When asked how satisfied they were with the process by which they were engaged by their respective Health Authority, Specialists gave an average rating of 4.4 out of 5.

Involvement in Health Authority Redesign Funded Projects

Respondents engaged in a variety of activities, ranging from e-Health program development to participation in cross-disciplinary care. Many Health Authority Representatives and some Specialists were involved with multiple projects. The following table summarizes Health Authority Redesign funded projects that were cited by respondents.[34]

Health Authority Redesign Projects Described by Respondents

Area	Project	Health Authority
General	Intercultural Online Health Network (ICON), which helps employ e-health technologies combined with live meetings to support multicultural patients with self management of disease. The project started in 2007 and is ongoing. The program is growing because of its success.	VCHA
Pediatrics	A redesign initiative that is studying the role and provision of pediatricians in acute and ambulatory care at Victoria General Hospital. The initiative includes about 12 physicians.	VIHA
Neurology	A redesign initiative to provide rural hospitals with iPads to have virtual 'face-to-face' consultations with Neurologists at Kelowna General Hospital if there is a neurological issue. The initiative completed a six month pilot and is now in knowledge translation. There were about 25 people involved in total.	IHA
Maternal Care	HerWay Home, which is a program to provide primary and Specialist care for pregnant and parenting women affected by substance use, mental health issues or violence. The program includes about six or	VIHA

[34] Please note that this is not an exhaustive list of initiatives undertaken by the various Health Authorities.

Area	Project	Health Authority
	seven physicians from across southern Vancouver Island.	
General	Shared Care Polypharmacy initiative, which was developed to improve the management of multiple medications for patients, primarily elderly patients. The project is being implemented in three phases, with the second phase starting in 2014.	PHSA
General	A redesign initiative to review emergency room admittance and streamline the flow of patients from the emergency room to hospital beds.	NHA
General	A redesign initiative to improve the continuity of care for patients seeing multiple doctors across multiples nodes and locations on Vancouver Island.	VIHA
Obstetrics	Perinatal Depression Strategy, which was a three year project, from 2010 to 2013, to bring together Psychiatrists and Obstetricians to develop a strategy for early detection and care of perinatal depression.	VCHA
Psychiatry	Mental Health and Substance Use Network, a program being developed to link the care network (family physicians, medical directors, etc.) across the Interior to psychiatric hospitals for access to Specialist services. The project was approved in concept in 2013 and is already showing success in bringing together different health care portfolios.	IHA
Bariatric Surgery	Bariatric Surgery Strategy, which was a strategy developed over four years to improve bariatric surgery provision. The SSC helped fund the first phase of the development which engaged Surgeons, Psychiatrists, Endocrinologists and Respirologists in the process.	PHSA
Psychiatry	A redesign initiative to develop an e-Mental Health service that offers those with mood disorders access a web portal with information on illness, diagnostic assessments and how to access psychological treatments.	VCHA

All Health Authority representatives and the majority of Specialists reported being very likely to participate in the initiative again in the future. Health Authority representatives noted a great need for multidisciplinary participation in such initiatives, and suggested that the initiative helps to improve Specialist engagement.

Specialists were similarly supportive of the initiative, and indicated that their clinical knowledge can help manage how care is provided. One Specialist, that is unlikely to participate in the Health Authority Redesign Funding initiative again, reported that the demands on his/her time limited his/her ability to participate. Three Specialists also reported being aware of physicians that chose not to participate in this initiative due to competing demands (particularly clinical work).

Satisfaction with the Process

Perceived Effectiveness in Bringing Together Specialists and Health Authorities to Improve the Delivery of Specialist Services

Respondents stated that that the initiative has been effective in bringing together Specialists and Health Authority representatives to improve the delivery of Specialist services. The following table summarizes respondents' respective ratings on a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.

How effective is the Health Authority Redesign Funding initiative in bringing together Specialists and Health Authorities to improve the delivery of Specialist services?

Respondent Group	Average Rating
Health Authority representatives	4.4
Specialists	5.0

Note: Specialists and Health Authority representatives that responded "Don't Know" and are excluded from the above ratings.

Health Authority representatives reported that that the initiative has increased their ability to engage Specialists in redesign projects, and that reimbursing Specialists for their participation suggests that Specialist input and advice is valued by their Health Authority. According to Health Authority representatives, this has facilitated a positive shift in the engagement between Specialists and Health Authorities, and has increased Specialists' willingness to participate in redesign projects.

Some ongoing challenges cited by Health Authority representatives include:

- **Ensuring ongoing Specialist participation.** Although Specialist participation in redesign initiatives has improved, respondents reiterated the ongoing challenge of ensuring participation. According to both Health Authority and Specialist respondents, sessional payments are insufficient with covering the compensation a Specialist receives from clinical work.
- **Ensuring unanimous commitment and support.** Respondents also reported that Division Heads' approval for Specialist participation in redesign initiatives is often required. Two Health Authority representatives reported that ensuring commitment and support from Division Heads for redesign projects can be challenging.

Most Specialists reported feeling that their input to the initiatives was valued by their respective Health Authorities.[35] Respondents stated that the culture of engagement is changing and that the lines of communication between Health Authorities and Specialists are improving. Respondents stated that working with their Health Authorities has helped lend credibility to their projects.

Most respondents did not experience any barriers to participation in the initiative. A few respondents noted competing demands and time management as drawbacks to participation.

Specialists' Satisfaction With the Reimbursement Process

Specialists were very satisfied with the reimbursement process through their respective Health Authority. As shown in the following table, respondents expressed high satisfaction with both the ease and timeliness of reimbursement.

How satisfied are you with the reimbursement process through your respective Health Authority?

How satisfied are you with:	Average Rating
The ease of the reimbursement process?	4.7
The timeliness of reimbursement?	4.5

Note: Specialists that responded "Don't Know" and are excluded from the above ratings.

[35] Note that three respondents could not comment on whether they feel that their input was valued, as their initiatives have not reached a stage where recommendations or Health Authority involvement has been needed.

Impacts and Effects of the Health Authority Redesign Funding Initiative

Overall Satisfaction With the Health Authority Redesign Funding Initiative

Respondents were satisfied with the Health Authority Redesign Funding projects in which they participated. As shown in the following table, the average rating from both Specialists and Health Authority representatives was 4.6 (on a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied).

Overall, how satisfied are you with the Health Authority Redesign Funding project(s) that you participated in?

Respondent Category	Average Rating
Health Authority Representatives	4.6
Specialists	4.6

Respondents noted a number of contributing factors to their satisfaction, including:

- **Improved communication and collaboration between Health Authorities and Specialists.** Respondents cited that the initiative improved communication and collaboration between Health Authorities and Specialists, and helped bring different views on redesign to the table.
- **Increased Specialist engagement.** Respondents also reported that the initiative increased Specialists' willingness to participate in projects because of the recognition that physicians' time is valuable and necessary in the redesign process. Respondents also acknowledged that physician engagement is necessary to facilitate buy-in and to support implementation.

Some reported drawbacks pertaining to the initiative include:

- **Uncertainty with securing ongoing funding.** The main concern cited by respondents was the uncertainty with securing ongoing or annual funding for successful projects. Some Health Authority representatives reported that ongoing funding is not guaranteed and that it is difficult to secure funding sources outside of the SSC to support the projects.
- **Slow process.** Some respondents noted dissatisfaction with the length of the overall process and project implementation. Respondents, however, acknowledge that the implementation of any system-wide change requires time.
- **Securing Health Authority support after the pilot stage.** Some Specialists reported that, although communication between Health Authorities and Specialists has improved, more ongoing support from Health Authorities is required after the initial project stages.

Satisfaction with Outcomes of the Health Authority Redesign Funding Initiative

Specialists were very satisfied with the outcomes of the projects; they generally reported that the projects in which they were involved have helped reach more patients and provide better patient care.

Overall, how satisfied are you with the outcomes of the Health Authority Redesign funded project(s) that you were involved in through your Health Authority?

Respondent Category	Average Rating
Specialists	5.0

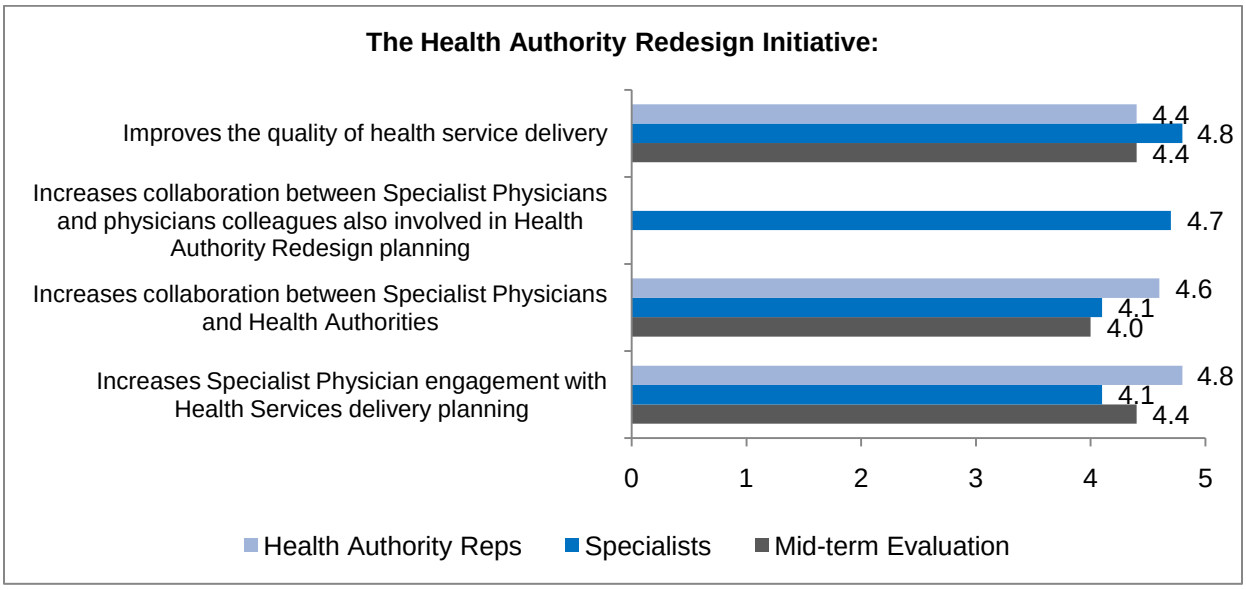
Note: Three respondents were not able to provide ratings, as their projects are still in early stages and have not yet reached any outcomes.

Impact and Effects of the Health Authority Redesign Funding Initiative

Health Authority representatives and Specialists rated the extent to which they agree that the initiative:

- Improves the quality of health service delivery.
- Increases collaboration between Specialists and physician colleagues also involved in Health Authority redesign planning.[36]
- Increases collaboration between Specialists and Health Authorities.
- Increases Specialist engagement with health service delivery planning.

Level of agreement was assessed on a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree. As reported in the following chart, respondents' perception ratings somewhat differed, but were fairly positive in all areas. The chart also includes a comparison to MNP's mid-term evaluation findings.[37]



Health Authority representatives stressed the importance of physicians' involvement in system redesign initiatives to ensure a sustainable and effective health care system. They noted that the initiative provided an "official structure" for such collaboration and that the funding helped to build commitment among Specialists.

Specialists also cited improved collaboration with other physician colleagues involved in Health Authority Redesign planning. Specialists generally felt that the inclusion of all health care providers in redesign initiatives helps provide better care for patients.

Success and Constraining Factors

Consistent with MNP's mid-term evaluation findings, respondents cited the following success factors:

- Access to funds to support Specialist engagement outside of clinical work.
- Improved collaboration and communication between Specialists and Health Authorities.
- Creation of innovative solutions and the ability to test them through funded pilot projects.

[36] Please note that only Specialist Physicians ratings were collected for this question.
[37] It should be noted that the mid-term evaluation included interviews with only Health Authority stakeholders.

Respondents cited the following factors as having constrained the success of the initiative:

- Projects typically require support from Divisions, which can be more difficult to obtain.
- There is risk that funding will not be approved by the SSC or that funding will not fully cover the project. Ongoing funding for projects is difficult to attain and the discontinuation of funding may affect project momentum.
- The redesign process requires significant time and dedication.
- Specialists' lack of awareness of the initiative limits its uptake. Some Specialists are also unwilling to learn new processes or use new technology.

It should be noted that a number of constraints that were commonly reported in MNP's mid-term evaluation were not perceived as issues in the outcome evaluation. These include:

- Lack of organizational readiness for Health Authorities.
- An arduous claims process for Specialists within a Health Authority.
- Difficulties for the SSC to coordinate with the Health Authorities.

The exclusion of these constraints in the final evaluation suggests that they may have been addressed.

Unexpected Results

Respondents did not cite any negative unintended outcomes that arose from the initiative. Some positive unintended outcomes included:

- The realization that a conversation between Health Authorities and Specialists should have always existed.
- The extent of success and impact of the initiative was somewhat unexpected.
- The successful development of additional solutions and processes originally unintended.

Lessons Learned

Specialists and Health Authority representatives reported the following lessons learned through the initiative:

- **Collaboration between health care professionals is critical to the development and implementation of redesign initiatives.** This allows each party to learn how the other functions, and helps to build trust and collaboration.
- **The importance of grassroots solutions.** Instead of the Health Authority determining redesign initiatives and then seeking Specialist involvement, Health Authority representatives cited processes where Specialists are asked to propose redesign projects.

Improvement Opportunities

Although respondents were generally satisfied with the initiative, they provided suggestions regarding how it could be improved. Recommendations included:

- **Securing sustainable funding for successful projects.** Respondents reported that sustainable support would help build momentum and improve the realization of intended outcomes. Respondents suggested further that multi-year or sustainable funding may advance systemic change.
- **Sharing best practices.** Some respondents stated that more dialogues around best practices be facilitated at the Health Authority level. Respondents suggested that more communication between Health Authorities regarding the types of projects planned, implemented and underway, as well as effective strategies and best practices, would be beneficial.
- **Providing more clarity regarding funding criteria and sources.** It was recommended that more clarity around funding criteria and funding sources would reduce confusion, and may improve the overall implementation of the initiative.

It is worth noting that the improvement opportunities suggested by Health Authority representatives in MNP's mid-term evaluation primarily focused on the implementation of the redesign funding. The key suggestion made by several Health Authority representatives in the mid-term evaluation was the need to address the lack of resources from a Health Authority perspective. It was also cited that collaboration with Specialists, as well as finding effective ways to engage and ensure their involvement, had been difficult. None of the main mid-term recommendations were repeated in the final evaluation.

5.6 PHYSICIAN SCHOLARSHIP FUNDING INITIATIVE

Key Findings

The key final evaluation findings for the Physician Scholarship Funding initiative were:

- **Specialists that participated in the initiative expressed high satisfaction with it.**
- **The majority of respondents used the funding to attend leadership and strategic planning training. Most respondents were also satisfied with the flexibility to choose their own leadership courses and conferences, as it provided them with an opportunity to choose initiatives that were suitable to their individual learning needs.**
- **All respondents reported having gained new skills that they have been able to apply in their own roles, and in working with their colleagues and respective Health Authorities.**
- **Respondents expressed concern regarding the limit on the level of funding for accommodation during courses or conferences attended through the initiative.**
- **The most commonly reported suggestion for improvement was increasing communication regarding awareness of the initiative. According to respondents, the initiative is not widely known by Specialists, and further efforts are needed to increase awareness of it among Specialists.**

Background on the Physician Scholarship Funding Initiative

To promote and/or further the work being undertaken within each Health Authority on behalf of the Health Authority Redesign initiative, the SSC has committed to fund scholarships for training of Specialists to enhance the redesign experience and outcomes, and support their professional growth.

Each year, the SSC, in partnership with BC's Health Authorities, contributes funding towards leadership training scholarships to cover tuition and travel costs.

Specialists interested in applying for Physician Scholarship Funding must submit an application form to the Vice-President of Medicine at their respective Health Authority for endorsement. Endorsed applicants are then submitted to the SSC for sub-committee funding approval.

To be eligible for endorsement, Specialists must fulfill the following criteria:[38]

- SSC scholarship funding is available for Specialists as certificants or fellows of the Royal College of Physicians and Surgeons of Canada.
- The scholarship funding is for the successful completion of training for leadership activities such as participation in system redesign, and Lean processes.
- Maximum funding of up to $10,000 per physician is available to cover actual tuition fees and travel costs.
- As part of the scholarship funding, physicians may be expected to participate in a SSC scholarship program evaluation.
- Time/compensation for attendance is excluded from funding.

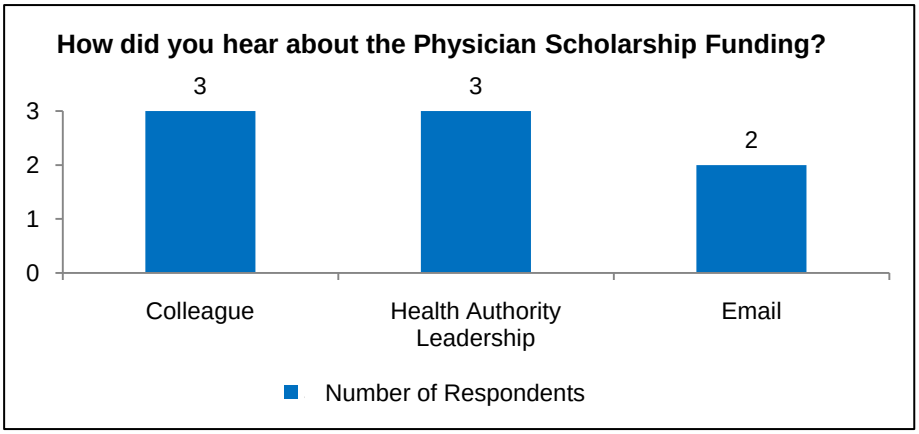
Endorsement is required from the Health Authority prior to the final approval of the SSC. The maximum SSC program funding is $250,000.

MNP's evaluation findings from telephone interviews with eight Specialists that obtained funding through the initiative are described below.

[38] Specialist Services Committee Leadership Training Scholarship Information.

Leadership Courses and Conferences Attended Through the Physician Scholarship Funding Initiative

Respondents learned of the initiative from three primary sources: colleagues, Health Authority leadership or email communication. Those who learned of the initiative through Health Authority leadership were informed of it by a Chief Medical Officer or a Vice-President. One respondent was alerted to it upon recruitment.



As described in the following table, most respondents used the funding to attend leadership and strategic planning courses. Others utilized the funding to participate in negotiation and conflict resolution courses, as well as society meetings or conferences.

Courses and Conferences Attended	Number of Specialists	Health Authority
Leadership and strategic planning courses	6	PHSA, VIHA, FHA
Negotiation and conflict resolution courses	3	PHSA, VIHA
Annual society meetings or conferences	2	PHSA, VIHA

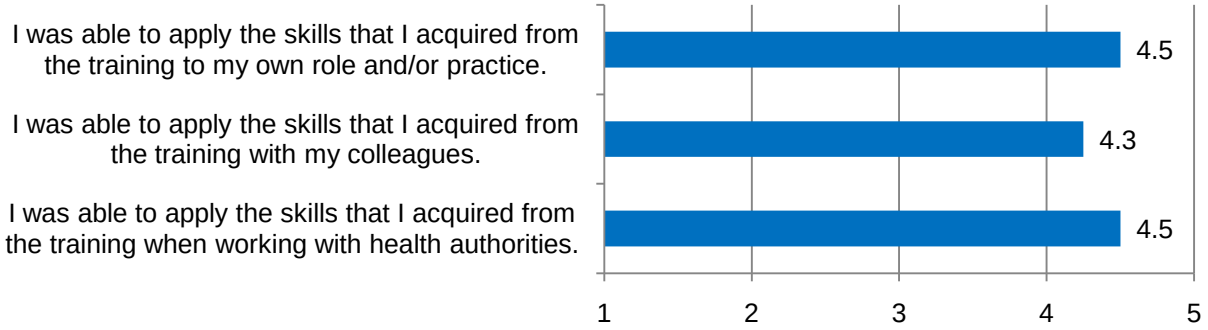
Note: Some Specialists took part in more than one initiative through the Physician Scholarship Funding initiative.

The most common provider of courses was the Physicians Management Institute. Other providers included the Canadian College of Health Leaders, Harvard University, Physician Executive Society and the Canadian Medical Association (CMA) Physician Leadership Institute. The most common location for courses was the Greater Toronto area, with Boston and Vancouver also being cited. Courses were generally only a few days in duration.

Impacts of the Physician Scholarship Funding Initiative

As reported in the following chart, respondents reported having acquired new skills that they have been able to apply to their own roles, share with their colleagues and use when working with the Health Authorities. The main proficiencies acquired by respondents included strategic planning skills, performance management skills, negotiation skills, active listening skills, leadership skills, teamwork and collaboration skills and conflict resolution skills.

From participating in the Physician Scholarship Funding initiative:



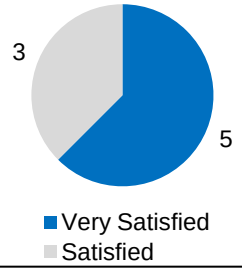
On a scale of 1 to 5, where 1 indicates that the skills acquired were not at all applicable and 5 indicates that the skills acquired were very applicable.

Most respondents reported that their acquired skills are more applicable to their leadership positions as opposed to their clinical work. For instance, five of the eight respondents felt that their acquired skills have helped them in a leadership capacity in terms of improving their relations with the physicians that report to them. Respondents cited performance management and strategic planning as skills they were able to share with their colleagues. They also reported that they were able to apply negotiation skills and process improvement knowledge when working with Health Authorities.

Satisfaction with the Funding Level and Approval Process

Respondents reported high levels of satisfaction with the funding level received through the initiative. However, two issues were raised regarding the funding level and related restrictions:

How would you rate the appropriateness of the funding level?



- **Accommodation allowance.** The Physician Scholarship Funding only reimburses up to a certain level for accommodation; however, many courses or conferences are held at hotels outside of the stipulated price range. This required Specialists to either pay for the difference or to stay at hotels located further away from the course or conference.
- **Opportunity cost.** The second issue raised was that the level of funding does not make up for the opportunity cost (e.g. lost clinical revenue) of taking time to complete a course or to attend a conference.

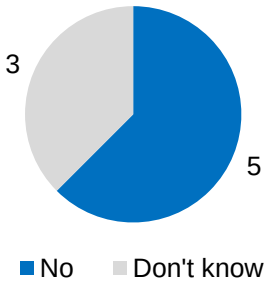
Respondents also expressed high satisfaction with the funding approval process. The following table summarizes respondents' average ratings regarding the ease of the application process and the timeliness of reimbursement, on a scale of 1 to 5, where 1 means not at all satisfied and 5 means very satisfied.

Specialists' satisfaction with	Average Rating
The ease of the process required to claim expenses	4.5
The timeliness of reimbursement	4.1

Satisfaction with the Physician Scholarship Funding Initiative

Respondents are, overall, satisfied with the initiative and the flexibility to choose their own leadership courses and conferences. Some respondents, however, noted the value of a more prescriptive approach to course selection. In particular, it was suggested that a more structured or prescriptive approach may identify a broad range of potential courses that may be unknown to a physician.

Would you prefer a more structured or prescriptive approach around the leadership course(s) and/or conference(s) that you could take?



All respondents reported that they would not have attended the courses or conferences in the absence of Physician Scholarship funding. The primary reasons for this included the high costs of the training. All respondents also reported that they will likely apply for Physician Scholarship Funding again in the future. Four respondents have already applied for more funding under the initiative, and three respondents are in the process of investigating additional courses and conferences in which to participate.

All respondents reported that they would recommend the courses or conferences taken to their colleagues, and that the skills they have gained (particularly leadership, negotiation, and conflict resolution skills) from participating in the initiatives are beneficial and applicable across all physicians. In addition, some respondents reported that the courses they took provided a broader context to healthcare, which allows for dissemination of best practices from across Canada and helps Specialists build a broader network of contacts in the health care system.

Improvement Opportunities

Recommendations made by respondents to further strengthen the initiative included:

- **Enhancing marketing efforts.** The most commonly reported suggestion for improvement was increasing communication of the initiative among BC physicians. The initiative is not widely known by Specialists and further efforts are needed to raise awareness of it.
- **Revisiting the reimbursement criteria.** Two respondents recommended that the reimbursement of full accommodation amounts should be considered by the SSC.
- **Considering offering leadership courses to resident physicians.** One respondent suggested providing resident physicians with opportunities for leadership training and raising their interest in leadership at the beginning of their careers.

5.7 SPECIALIST ADVANCED CARE PLANNING FEE

Key Findings

The key final evaluation findings for the Specialist Advanced Care Planning Fee were:

- **The majority (84%) of survey respondents had experience with Advanced Care Planning and plan development, and most (74%) reported being "comfortable" or "very comfortable" with having Advanced Care Planning discussions with their patients.**
- **Nonetheless, survey results demonstrated that respondents were largely unfamiliar with the Specialist Advanced Care Planning fee, and 72% had never billed/claimed the fee. About a third (33%) of respondents did not bill the fee because they were unfamiliar with the appropriate billing procedures.**
- **Almost half (47%) of respondents that were compensated on a fee-for-service (FFS) payment arrangement perceived the fee to be inappropriate.**
- **Nonetheless, respondents generally perceived the fee as useful in assisting with Advanced Care Planning.**
  - **The most commonly reported suggestions among respondents for improvement included increasing the fee to a level that is commensurate with the time expended (e.g. time-based fee), increasing marketing efforts to enhance awareness of the fee among Specialists, and providing more upfront information regarding the specific fee requirements and documentation.**

Background on the Advanced Care Planning Fee

Advance Care Planning is when a capable adult thinks about and discusses their beliefs, values and wishes for future health care, in the event the adult becomes incapable of making such decisions in the future. The adult may have Advance Care Planning discussions with close family or trusted friends and health care providers. When an adult's wishes are written down, they become an Advance Care Plan.

With the aim of supporting the government's My Voice[39] Advance Care Planning tools and encouraging Advance Care Planning discussions, a Specialist Advanced Care Planning fee premium of $40[40] was developed in 2012.[41] The goal of the fee is to improve coordination with primary care providers and make opportunities for discussion with patients around Advance Care Planning decisions.[42]

[39] My Voice – Expressing My Wishes for Future Health Care Treatment. Advance Care Planning Guide. February 2013. http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf
[40] The fee is not payable to physicians on salary, sessional or service contract arrangements.
[41] SSC Report for the Period 2010/11 and 2011/12. http://www.sscbc.ca/sites/default/files/SSC_AR%20WEB_0.pdf
[42] Ibid

The MSP fee is paid only to Specialists that have Advance Care Planning discussions and develop Advanced Care Plans with patients presented with a chronic medical illness or complex co-morbidities and a deteriorating quality of life or end-stage disease state. [43]

The Advance Care Planning discussion needs to include sharing information and resources on how a patient can create an Advance Care Plan. Such care plan form, as illustrated by the preceding sample template, must also be completed and added to the patient's chart, and the discussion must be summarized in the consultation report. The care plan template form must then be shared with the patient as well as the patient's primary health care provider. Information contained in the Advanced Care Plan must be consistent with the Practice Support Program's End of Life Module resources.[44]

Some claim limits of the Advanced Care Planning Fee include the following:[45]

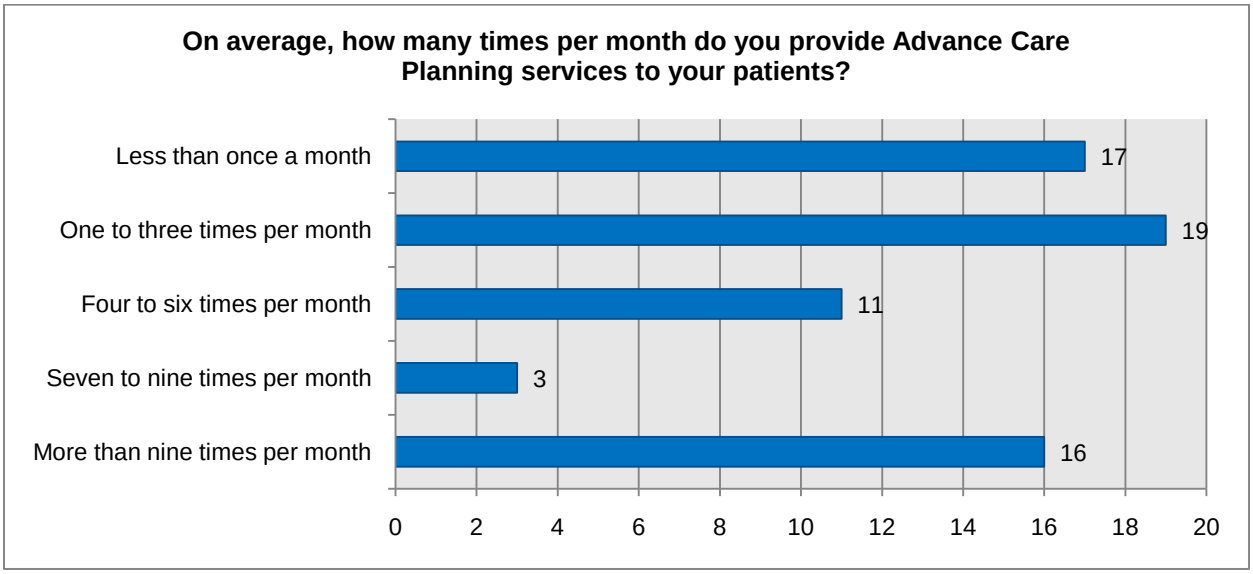
- Not paid with adult and pediatric critical care (01400 series), or neonatal intensive care (01500 series) per hospital admission
- Not paid for physicians on salary, sessional, or service contract arrangements

During the period from April 1, 2013 to October 31, 2013, the fee was utilized by 91 Specialists that rendered 1,174 services billed under this MSP fee code.[46]

MNP's evaluation findings from 31 "high users" (i.e. Specialists belonging to Internal Medicine and Nephrology Sections) and 16 "low users" (i.e. Specialists belonging to Neurology and Cardiology Sections) of the Advanced Care Planning Fee are described below. It should also be noted that an additional 34 Specialists from a variety of sections also participated in the online survey.[47]

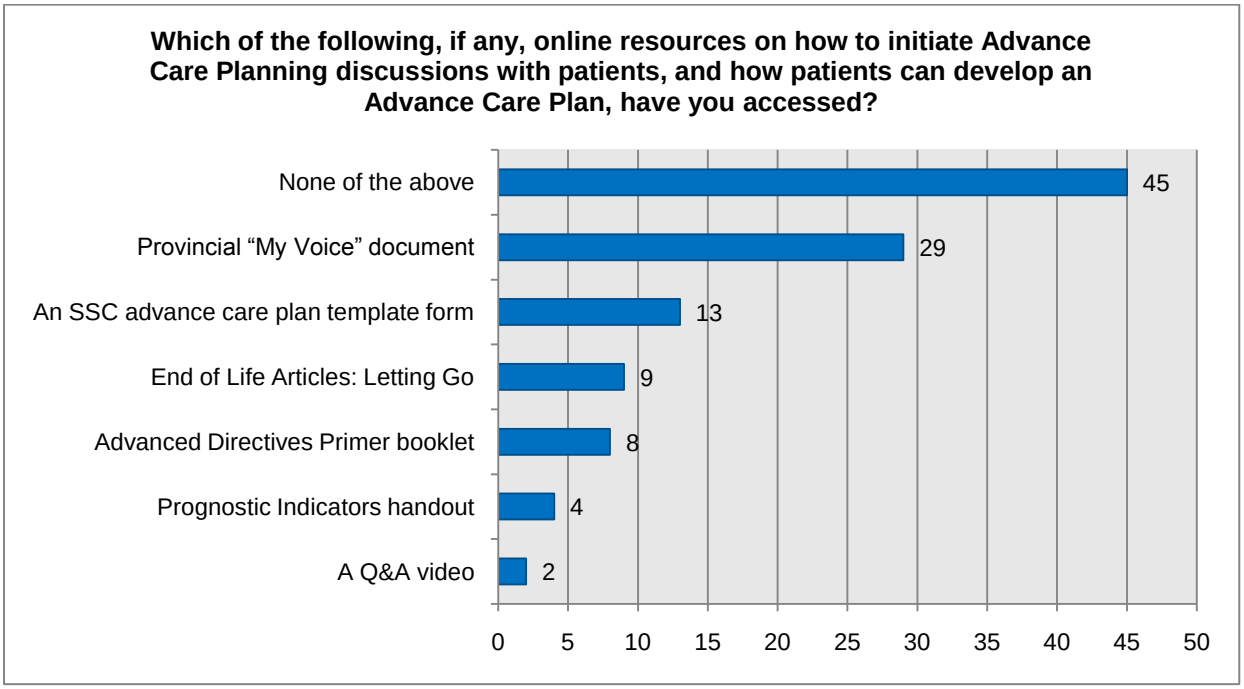
Involvement with Advanced Care Planning

The majority (84%) of respondents had experience with Advanced Care Planning and plan development. For those that have a history of providing Advance Care Planning services, almost half (45%) provide the services one to six times per month, as reported in the following chart.

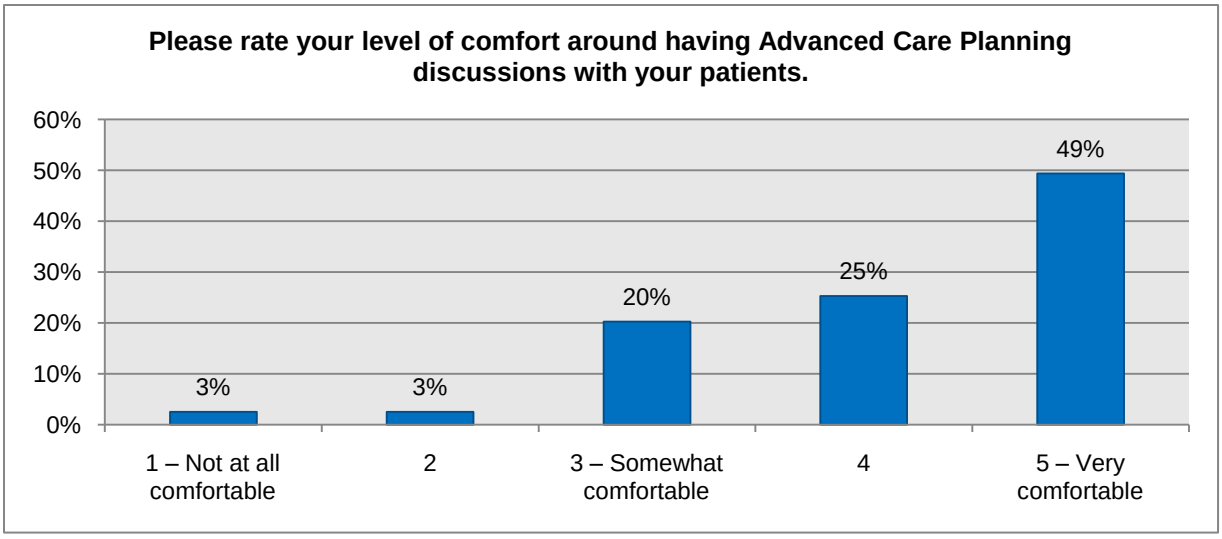


[43] http://www.sscbc.ca/fees/advance-care-planning
[44] Ibid
[45] Ibid
[46] MSP claims files retrieved from the Doctors of BC.
[47] Other sections represented within the survey include: Allergy and Immunology, Critical Care, Endocrinology, Gastroenterology, Geriatric Medicine, Haematology & Oncology, Infectious Diseases, Paediatrics, Respirology, and Rheumatology.

As illustrated in the following chart, 41% of respondents did not access any online resources relating to Advance Care Planning. About a quarter (26%) of respondents, however, identified the Provincial "My Voice" document as a resource they had previously accessed.



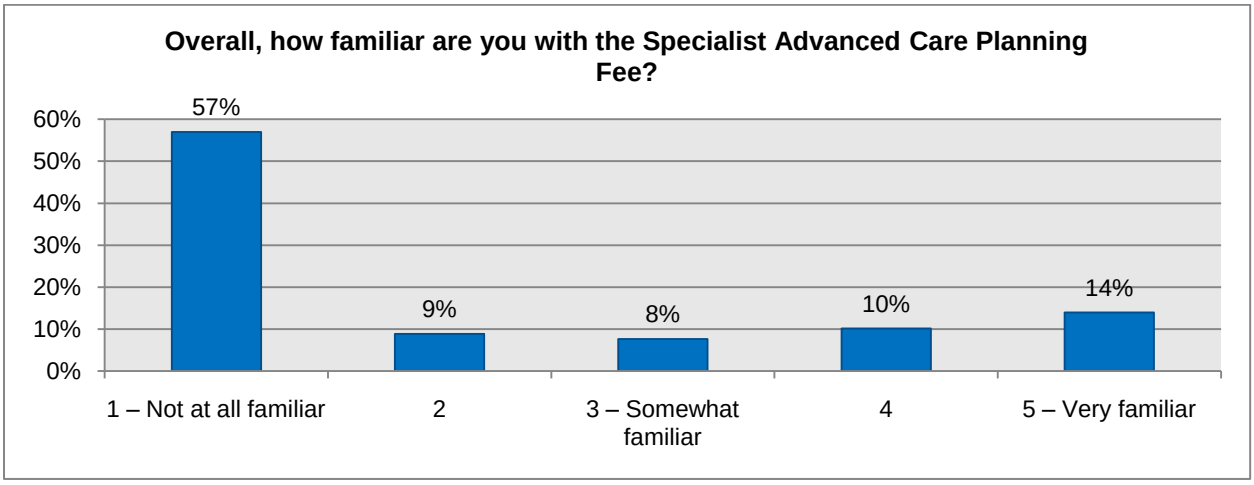
Most (74%) respondents are "comfortable" or "very comfortable" with having Advanced Care Planning discussions with their patients.



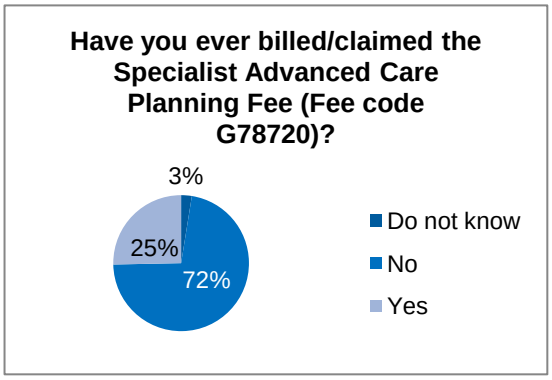
Respondents spoke frequently to their experience with managing elderly patients, along with other complex patients suffering from multiple co-morbidities. Some respondents related their level of comfort to the frequency with which Advanced Care Planning discussions occurred within their speciality.

Utilization of the Advanced Care Planning Fee

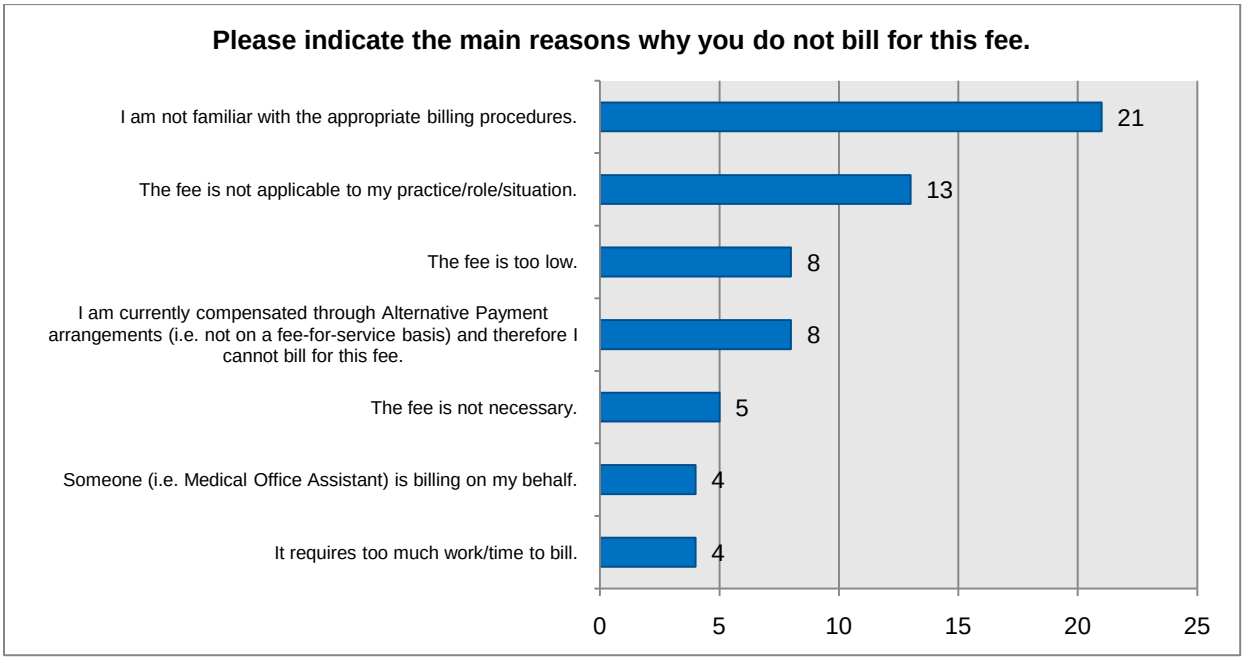
Respondents were largely unfamiliar with the fee. As indicated in the following chart, over half (57%) of respondents were not at all familiar with the fee.



Similarly, when asked whether they had ever billed/claimed the fee, the majority (72%) said that they had not.



The following chart summarizes the main reasons why respondents did not bill the fee. About a third (33%) of respondents did not bill the fee because they were unfamiliar with the appropriate billing procedures. Twenty-one percent deemed the fee non-applicable to their roles, practices or situations. Other common reasons related to Specialists being compensated through Alternative Payment Plan arrangements, or the fee being perceived as too low.



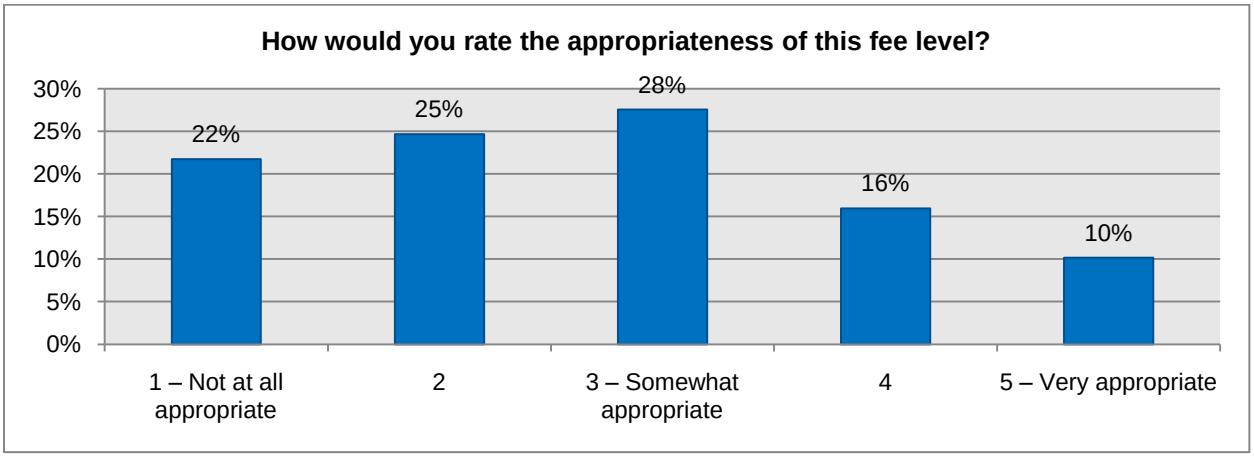
Respondents described a number of resources that would be beneficial in assisting them with Advanced Care Planning. The most commonly cited resources included:

- Booklets or mobile applications related to Advanced Care Planning.
- Easy to navigate websites with relevant information on palliative care benefits, as well as home care and hospice referral forms and "Do Not Resuscitate" (DNR) forms.
- Web-based information or pamphlets for patients to refer to before discussing Advance Care Planning.

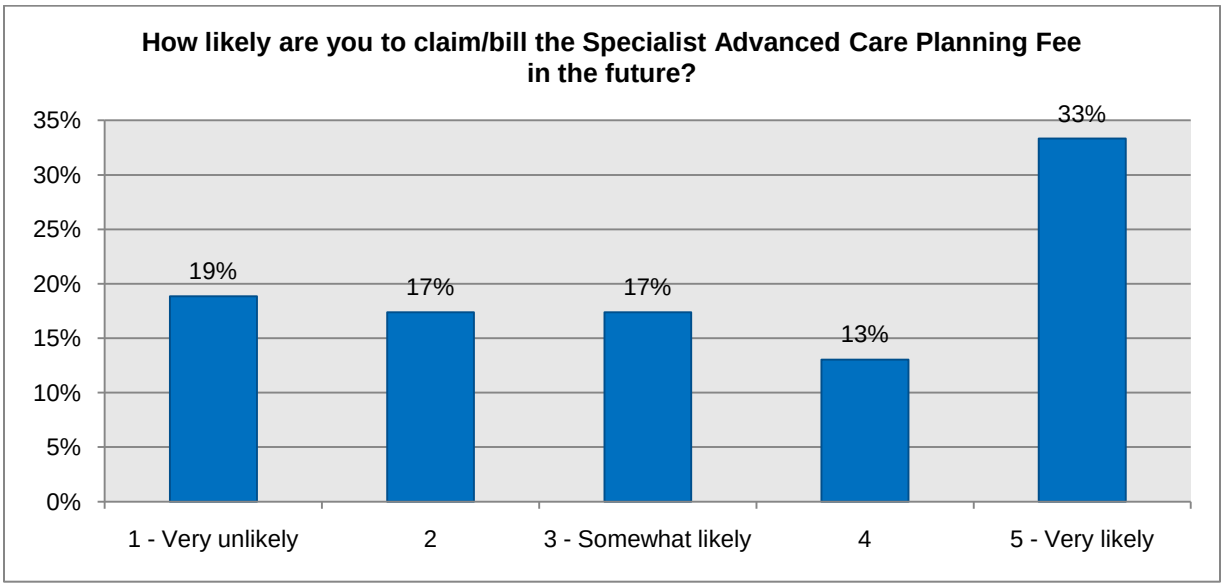
Respondents also cited the need for more upfront instruction with regard to billing procedures and required forms. Several respondents added that, in order for them to begin billing the fee, they require clarification on the required actions, documentation and deliverables, in addition to examples of discussions and scenarios that would be deemed appropriate for claiming the fee.

Appropriateness of the Fee Level

As shown in the following chart, almost half (47%) of respondents perceived the fee to be inappropriate. Several respondents reported that the time required to fulfill the necessary billing requirements is not commensurate with the compensation.



Nonetheless, 63% of respondents were at least somewhat likely to claim the fee in the future.

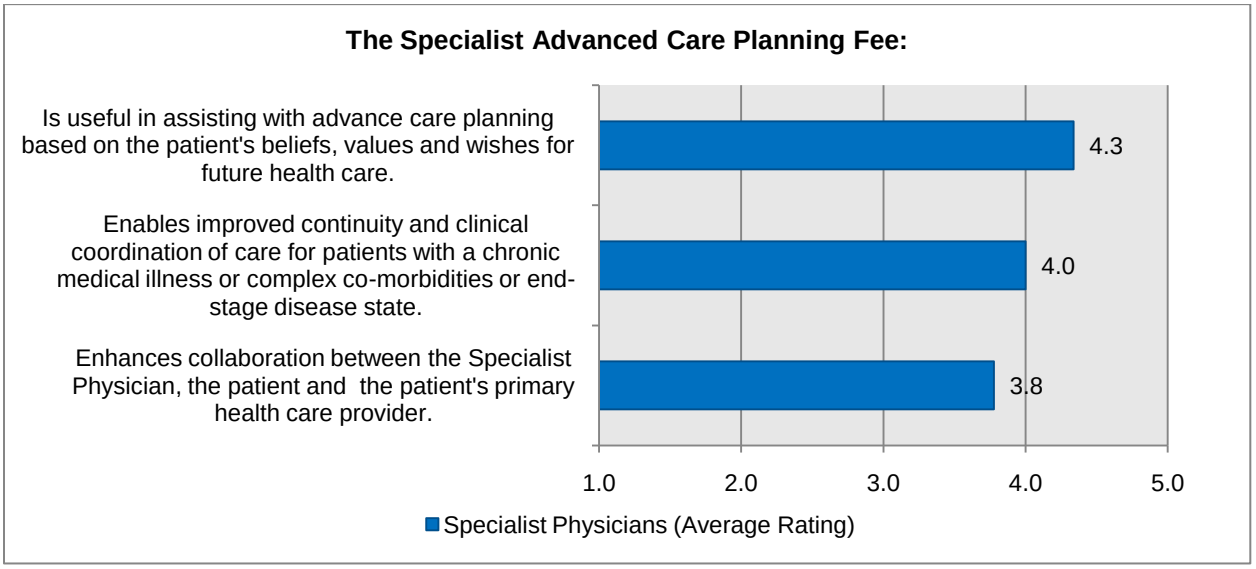


Impacts and Usefulness of the Advanced Care Planning Fee

Respondents rated the extent to which they agreed that the fee:

- Enhances collaboration between the Specialist, the patient and the patient's primary health care provider.
- Enables improved continuity and clinical coordination of care for patients with a chronic medical illness or complex co-morbidities or end-stage disease state.
- Is useful in assisting with Advance Care Planning based on the patient's beliefs, values and wishes for future health care.

Impact was assessed on a scale of 1 to 5, where 1 means strongly disagree, 3 is neither agree nor disagree, and 5 means strongly agree.



Respondents generally acknowledged the importance of the fee as an incentive for Specialists to facilitate discussions and develop plans with respect to Advanced Care Planning. One respondent noted that the fee had contributed to more Advance Care Planning discussions, which helped their patients and their families come to terms and accept appropriate decisions regarding patient care. In contrast, another respondent cited cultural barriers as a challenge to facilitating Advance Care Planning discussions.

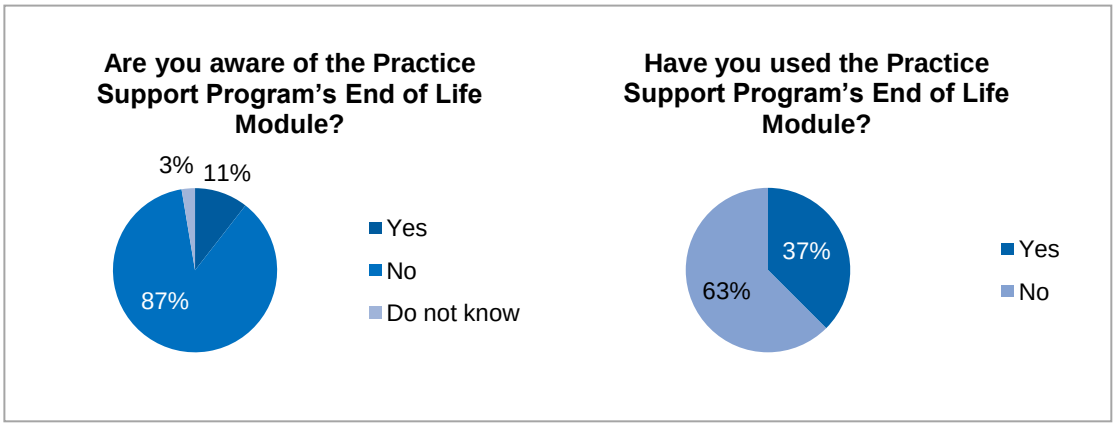
Improvement Opportunities

When asked to articulate recommendations associated with improving the fee, respondents most commonly suggested:

- **Increasing the fee to a level that is commensurate with the time expended** (e.g. time-based fee). Respondents added that, in most cases, Advanced Care Planning discussions evolve over time.
- **Increasing marketing efforts** to enhance awareness of the fee among Specialists.
- **Providing more upfront information in regards to the specific fee requirements and documentation**.

The majority (65%) of respondents supported the idea of offering Specialists further training and/or resources to learn about Advance Care Planning in more detail. Nine percent of respondents did not find it necessary to further educate Specialists on the subject, and 25% of respondents were unable to comment.

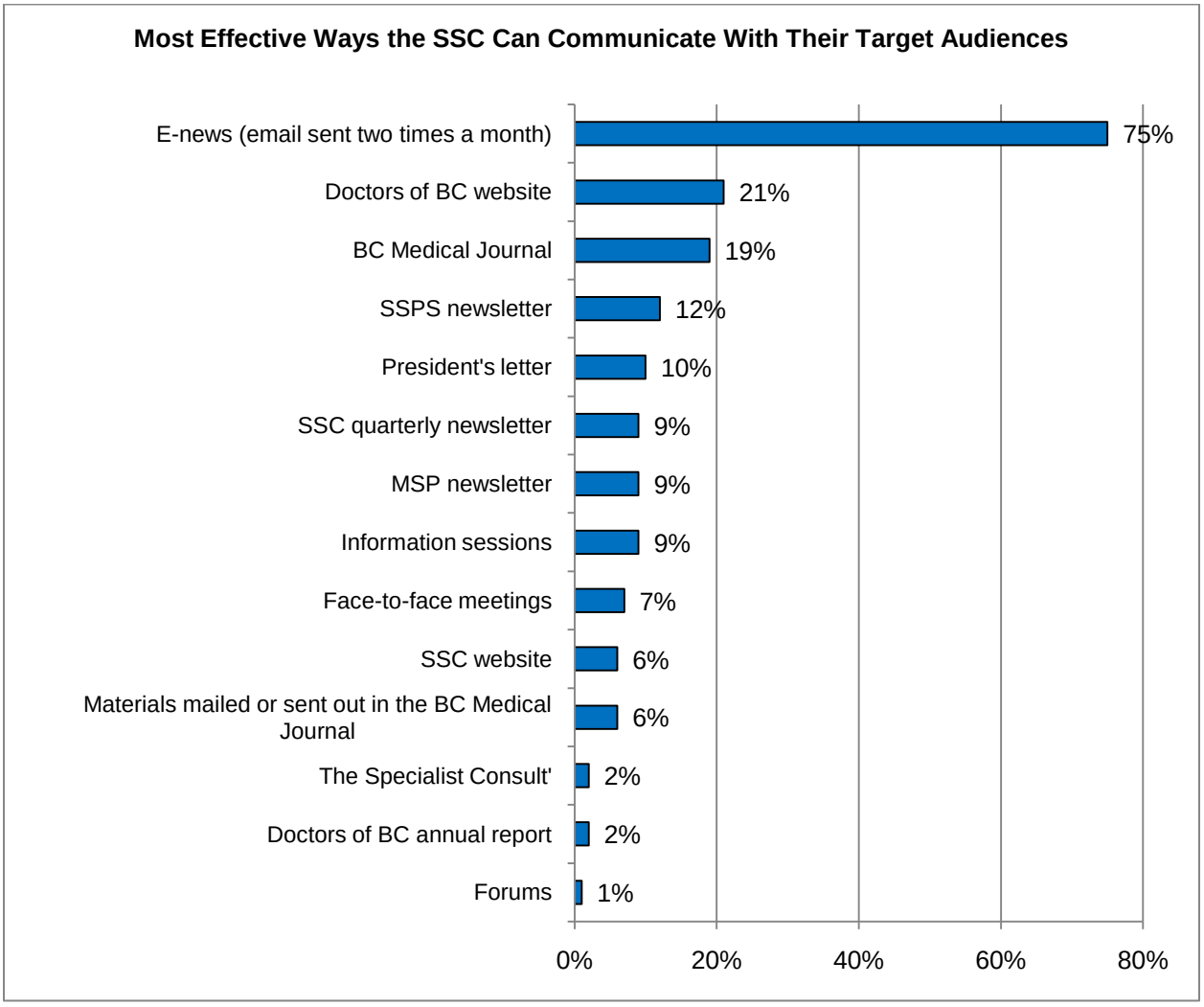
The majority (87%) of respondents were not aware of the Practice Support Program's (PSP's) End of Life Module.[48] Only 11% of respondents had previously heard of the module; however, the majority (63%) did not utilize it. Only 37% (3 respondents) reported having used the module as a resource.



[48] The End of Life Module provides training for practitioners to improve care of patients and families living with, suffering and dying from life-limiting and chronic illnesses. Physicians learn how to identify patients that could benefit from a palliative approach to care; increase confidence and communication skills to enable Advance Care Planning conversations; and improve collaboration with providers, patients, families and caregivers.

5.8 FUTURE SSC COMMUNICATION

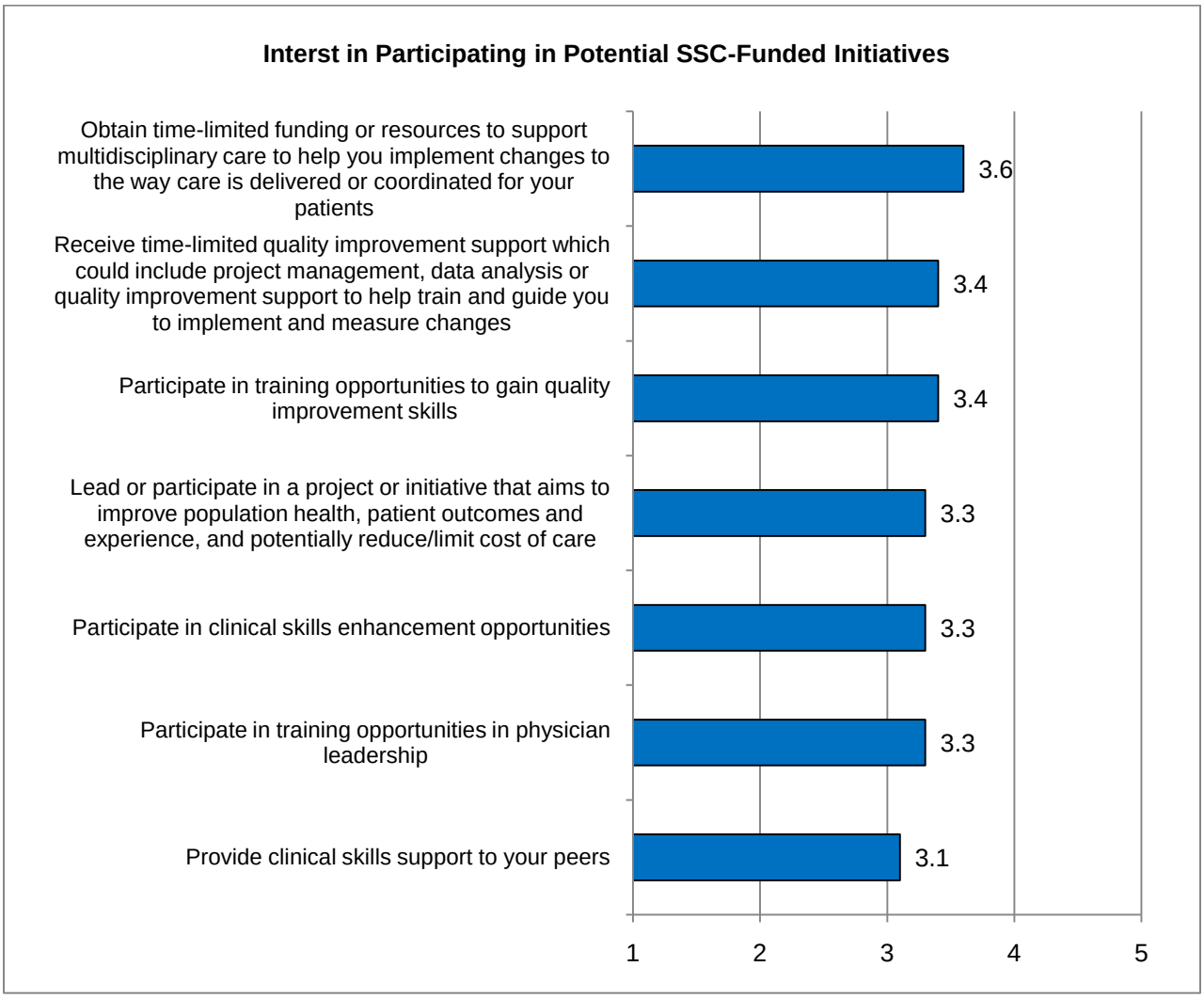
To gauge what they deem to be the most effective means of communication between Specialists and the SSC, all interview and survey respondents of this evaluation were asked to report the most effective way of communication on existing as well as future SSC initiatives. The graph below summarizes the responses of this study's sample population.



As reported in the above graph, the majority (75%) of respondents preferred to receive email updates twice a month. Some respondents also provided other suggestions regarding effective communication, including communication to individual Sections (i.e. through Section newsletters and e-blasts) and small academic counselling group meetings.[49]

Furthermore, to assess representatives' level of personal interest in participating in potential SSC-funded activities during the upcoming year, respondents (with the exception of Health Authority representatives) were asked to rate (on a scale of 1 to 5, where 1 means not at all interested and 5 means very interested) their interest in participating in each of these potential SSC-funded activities. The following graph summarizes respondents' average ratings with regard to each potential initiative.

[49] One respondent reported that such networking and knowledge sharing meetings are currently organized by the South Island Division of Family Practice's Partners in Care program in partnership with the Victoria Division of Family Practice.



As illustrated in the chart above, respondents are most interested in obtaining time-limited funding or resources to support multidisciplinary care to help them implement changes to the way care is delivered or coordinated for their patients.

Although the majority of respondents showed an interest in participating in such potential initiatives in the future, many noted time constraints associated with high workloads, clinical care and research, teaching, other General Practitioner-led projects or initiatives, and personal matters that prohibit them from active participation. Others have suggested that, for such initiatives to be successful, buy-in, support, and engagement from Health Authorities is pivotal. A few respondents also noted that a provincial database that monitors and compares outcomes to benchmarks for all quality improvement initiatives is needed. The idea of a mechanism that compares national and provincial health care quality improvement related statistics was deemed to be beneficial in evaluating the differences across regions and Health Authorities.

6 KEY CONCLUSIONS AND RECOMMENDATIONS

6.1 OVERALL CONCLUSIONS AND RECOMMENDATIONS

MNP's overall conclusions and recommendations fall into three categories:

1. Communication and marketing of SSC initiatives
2. Collaboration and consultation with allied health professionals
3. Ongoing performance measurement

Initiative-specific recommendations are summarized in **Section 6.2**.

1. Communication and marketing of SSC initiatives

Consistent with MNP's mid-term evaluation findings, Specialists' lack of familiarity with SSC initiatives limits their uptake. For instance, while the majority of Specialists surveyed had experience with developing a discharge plan, they were largely unfamiliar or only somewhat familiar with the Complex Care Discharge Planning Fee. Similarly, the majority of Specialists surveyed had experience with Advanced Care Planning and felt comfortable with having such discussions with their patients, but were largely unfamiliar with the Specialist Advanced Care Planning fee. A lack of familiarity with SSC initiatives among Specialists was also expressed during MNP's interviews with those that had previously claimed the GMV fees and those who had participated in the Physician Scholarship Funding initiative. In both cases, respondents agreed that the GMV Fees for Specialists and Physician Scholarship Funding initiative were not well known among BC Specialists, and that further marketing effort is needed to raise their profiles among Specialists.

Widespread, focused marketing could improve uptake of SSC initiatives and increase the likelihood of achieving program objectives. Ensuring that Specialists are informed of the purpose, priorities and scope of initiatives may result in fewer barriers to agreement and increased adoption among Specialists.

The majority of survey and interview respondents stated that the most effective means of communication with the SSC is twice-monthly email updates. The SSC should thus focus its marketing efforts on the dissemination of relevant initiative-specific information through email communication.

The following considerations are recommended to improve communication and marketing of SSC initiatives:

- **Clearly articulate program objectives, potential benefits and appropriate billing procedures, and create effective marketing materials.** The uptake of both the Complex Care Discharge Planning Fee and the Advanced Care Planning Fee was compromised by Specialists' lack of familiarity with the appropriate billing procedures. In both cases, about a third of survey respondents reported not claiming/billing these fees because they are unfamiliar with the appropriate billing procedures. Uptake of the fees may be improved by clearly communicating the fees' purpose, requirements and billing procedures.
- **Engage Specialists through encouraging word-of-mouth communication, especially by Specialists utilizing or participating in SSC initiatives.** Specialists that had previously claimed the GMV fees or had completed the PSP module for GMVs reported that Specialists may be more likely to offer GMVs in their practice if their patients or colleagues approached them with positive recommendations based on their experience with GMVs.
- **Engage Sections individually.** The applicability of SSC initiatives varies among Specialist Sections. Marketing efforts could therefore be tailored to individual Sections. This could be accomplished through Section newsletters and e-blasts, as well as by identifying and utilizing Specialists within each Section to articulate and promote the initiatives.

2. Collaboration and consultation with allied health professionals

Opportunities exist to improve collaboration and consultation among allied health professionals. Although the outcome evaluation findings suggest that some SSC initiatives have contributed to increasing collaboration between Specialists and Health Authorities and allied health professionals, many interview respondents highlighted the need for more cooperation in this regard. For instance, Health Authority representatives and Specialists expressed that the Health Authority Redesign initiative had positively affected collaboration between Health Authorities and Specialists, and that there is a perceived shift in culture toward an expectation that Specialists will remain involved in redesign initiatives. Nonetheless, respondents generally felt that the inclusion of all health care providers in redesign initiatives helps to provide better care for patients.

Similarly, when asked to comment on the supports that make GMVs an effective part of their practice, all Specialists interviewed provided positive feedback regarding the involvement of allied health professionals (e.g. dieticians, pharmacists, physiotherapists, nurses). A common suggestion for improving GMVs included adding more resources to enable greater collaboration with allied health professionals.

We recommend that the SSC create additional opportunities to increase collaboration and knowledge-exchange between Specialists and allied health professionals. Annual face-to-face meetings, regular email communication and website updates and publications are some of the ways in which information exchange and collaboration could be facilitated.

3. Ongoing performance measurement

We recommend the development and implementation of an ongoing performance measurement system that is aligned with the Triple Aim Initiative, the SSC's guiding principles and initiative-specific objectives. Such a system could, on an ongoing basis, inform the SSC and relevant stakeholders of the state of the initiatives and the extent to which intended goals have been achieved. Findings could be used to regularly modify and improve the initiatives. Such a system may be particularly beneficial with monitoring and forecasting future fee code utilization. In the case of new fee codes established under the LMA initiative, for instance, a performance measurement system may avoid overlap of fee codes, review fee code utilization, and assess improvements in patient care.

Ongoing performance monitoring and regular progress updates may also help to increase accountability and to instigate appropriate actions based on reported results. We suggest the following:

- For each initiative, we suggest that the SSC determine the expected results and outcomes and communicate those expected results to relevant stakeholders. Indicators related to the expected outcomes should be communicated to ensure that appropriate data are collected and are available for follow-up.
- We suggest that the SSC develop necessary processes to collect and report performance measurement data. The committee should also identify sources for collecting performance data, develop data collection tools, and develop timelines for data collection and reporting. Performance data reflecting initiative-specific outputs (i.e. number of stakeholders involved, number and types of tools and resources produced, etc.) and outcomes (i.e. changes in Specialists' knowledge, capacity, and attitudes, types of changes in policies and procedures, etc.) should be collected on a regular basis.

We suggest that an evaluation update in the form of a 'reporting dashboard' be prepared for the SSC on a quarterly or bi-annual basis. Such a tool would provide a summary of the status and key highlights of each of the committee's initiatives. A sample graphic representation of a reporting dashboard can be found in **Appendix C**.

6.2 INITIATIVE-SPECIFIC RECOMMENDATIONS

The following table summarizes initiative-specific recommendations for improvement by theme.

SUMMARY OF INITIATIVE-SPECIFIC RECOMMENDATIONS BY THEME

SSC Initiative	*Recommendations for Improvement*			
	Marketing	**Compensation/ Fee Structure/ Funding**	**Administration/ Delivery Structure/ Performance Measurement**	**Collaboration and Information Sharing**
1. Complex Care Discharge Planning Fee	• Enhance marketing efforts to foster greater awareness of the Complex Care Discharge Planning fee amongst physicians.	• Consider increasing the fee level. • Consider reducing restrictive criteria associated with the fee. • Consider implementing the fee on a time-basis, allowing the fee to rise with the amount of time spent developing the discharge care plan.	• Develop standardized electronic templates across all Health Authorities to reduce the administrative burden.	
2. Group Medical Visit Fees for Specialists	• Improve awareness and marketing of GMV Fees for Specialists. Respondents agreed that patient and physician awareness of GMVs should be improved.	• Consider increasing the GMV fee amount per patient. • Consider adding an addendum to the GMV fees to allow Specialists to offer GMVs for education and knowledge transfer. • Consider adding an addendum to the GMV fees to allow remuneration for one-on-one patient follow- ups.		• Add resources to enable greater collaboration with allied health professionals.
3. Labour Market Adjustment initiative		• Ensure that ongoing funding is available as the utilization of new fee codes rises.	• Establish a more effective mechanism to estimate fee code utilization in advance of future implementations. • Improve monitoring mechanisms and tools to avoid fee codes that overlap, review utilization and	

SSC Initiative	Recommendations for Improvement			
	Marketing	**Compensation/ Fee Structure/ Funding**	**Administration/ Delivery Structure/ Performance Measurement**	**Collaboration and Information Sharing**
			analyze whether fees are leading to improved patient care. • Provide Sections with more up-front information on the consequences and implications of under and/or over-utilization of fee codes implemented as a result of the initiative. • Consider the applicability of successful fees for other Sections.	
4. Health Authority Redesign Funding initiative		• Secure sustainable funding. Respondents reported that sustainable support would help build momentum and improve the realization of intended outcomes.	• Provide more clarity regarding funding sources and funding criteria.	• Share best practices among Health Authorities.
5. Physician Scholarship Funding initiative	• Improve marketing efforts to further promote the initiative among Specialists.	• Consider revising reimbursement criteria.	• Consider offering leadership courses to resident physicians.	
6. Specialist Advanced Care Planning Fee	• Increase marketing efforts to enhance awareness of the fee among Specialists.	• Consider increasing the fee to a level that is commensurate with the time expended (e.g. time-based fee).	• Provide more upfront information in regards to the specific fee requirements and documentation. • Offer further training and/or resources to Specialists.	

APPENDIX A – DATA COLLECTION TOOLS

COMPLEX CARE DISCHARGE PLANNING FEE SURVEY

ABOUT THE SURVEY

This survey is being conducted by MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). The survey is part of a final evaluation of six SSC initiatives, including the Complex Care Discharge Planning Fee.

The survey results will be used to assist in assessing the relevance and performance of the Complex Care Discharge Planning Fee and determining whether the initiative has achieved its overall intended goals and objectives to date.

Your participation is voluntary and all information collected will be treated as confidential.

Please complete the following survey **prior to June 30, 2014**. All completed surveys, received by MNP prior to June 30, 2014, will be entered into **a draw for a chance to win an iPad**. A representative from the Doctors of BC will contact you if your name has been drawn.

About MNP

MNP is one of the largest chartered accountancy and consulting firms in Canada, providing client-focused accounting, taxation and consulting advice. National in scope and local in focus, MNP has proudly served individuals and public and private companies for more than 65 years. For more information, visit www.mnp.ca

CLASSIFICATION QUESTIONS

The following questions are for classification purposes.

Are you male or female?

- ☐ Male
- ☐ Female

What is your specialty?

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ Chest Surgery
- ☐ Critical Care
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Internal Medicine
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Haematology & Oncology
- ☐ Infectious Diseases
- ☐ Medical Microbiology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics & Gynaecology
- ☐ Ophthalmology
- ☐ Orthopaedic Surgery
- ☐ Otolaryngology
- ☐ Paediatrics
- ☐ Pathology
- ☐ Physical Medicine
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Radiology
- ☐ Respirology
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other (please specify _____)

How many years have you been practicing as a Specialist Physician?

- ☐ Less than 1 year
- ☐ 1 to 3 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ 10 to 15 years
- ☐ Over 15 years

Which of the following best describes your practice?

- ☐ Primarily hospital-based
- ☐ Primarily community-based
- ☐ Other (please specify _____)

In what health authority do you practice most often?

- ☐ Fraser Health Authority
- ☐ Interior Health Authority
- ☐ Vancouver Island Health Authority
- ☐ Northern Health Authority
- ☐ Vancouver Coastal Health Authority
- ☐ Provincial Health Services Authority

INVOLVEMENT WITH THE INITIATIVE

1. **Have you ever been involved with the development of a discharge plan?**

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

IF RESPONDENT SAID "NO" SKIP TO QUESTION 8. IF ANSWERED "DON'T KNOW", SKIP TO QUESTION 3.

2. **(If yes) Based on your experience, please provide a brief profile of complex patients that require a discharge plan** (i.e. particularly complicated cases, patients that require community support upon discharge, patients that may be at risk of re-admission, etc.).

3. **Overall, how familiar are you with the Complex Care Discharge Planning Fee?**

(On a scale of 1 to 5, where 1 is not at all familiar, 3 is somewhat familiar and 5 is very familiar.)

1 – Not at all familiar	2	3 – Somewhat familiar	4	5 – Very familiar	Don't Know

The Complex Care Discharge Planning Fee is intended to support clinical coordination leading to effective discharge and community based management of complicated patients. It is to be billed for patients that require community support upon discharge and are at risk of re-admission.

The fee is $75.00 and is applicable to the Most Responsible Physician (MRP) coordinating the hospital discharge for a complex patient with a stay greater than four days. The fee premium requires, among other services, a written discharge care plan for the patient and communication with the patient's primary health care provider.

For more information on this fee, please visit: http://www.sscbc.ca/fees/discharge-care-plan-complex-patients-fee

UTILIZATION OF FEE

4. **Have you, or someone on your behalf, ever billed/claimed the Complex Care Discharge Planning Fee (Fee code G78717)?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

IF RESPONDENT SAID "NO" OR "DON'T KNOW", SKIP TO QUESTION 4C.

IF RESPONDENT SAID "YES", PROCEED WITH QUESTION 4A.

4a. (If yes) On average, how many times per month do you bill/claim the Complex Care Discharge Planning Fee?

- ☐ Less than once a month
- ☐ One to three times per month
- ☐ Four to six times per month
- ☐ Seven to nine times per month
- ☐ More than nine times per month
- ☐ Don't Know

4b. Based on your experience, are there complex patients that you do not bill for?

- ☐ Yes

- ☐ No
- ☐ Don't Know

(If yes) Please provide a brief profile of complex patients that are <u>not billed for.</u>

4c. (If no or don't know) Please indicate the main reason(s) why you have not billed for this fee. *Please check all that apply.*

- ☐ The fee is not applicable to my practice/role/situation (Please elaborate _____).
- ☐ I transferred Most Responsible Physician (MRP) responsibility to a GP, Hospitalist or other Specialist during the patients' hospital stay and therefore I am not the physician responsible for discharge planning.
- ☐ I am currently compensated through Alternative Payment arrangements (i.e. not on a fee-for-service basis) and therefore I cannot bill for this fee.
- ☐ The fee is not necessary (Please elaborate _____).
- ☐ It requires too much work/time to bill (Please elaborate _____).
- ☐ I am not familiar with the appropriate billing procedures.
- ☐ The fee is too low.
- ☐ Other (Please specify _____).

IF RESPONDENT SAID "I AM CURRENTLY COMPENSATED THROUGH ALTERNATIVE PAYMENT ARRANGEMENTS (I.E. NOT ON A FEE-FOR-SERVICE BASIS) AND THEREFORE I CANNOT BILL FOR THIS FEE", SKIP TO QUESTION 8.

4d. (If respondent answered "I transferred MRP responsibility to a GP or Hospitalist during the patients' hospital stay and therefore I am not the physician responsible for discharge planning") Who is the Most Responsible Physician (MRP)? Please specify whether the MRP is a Specialist Physician (and, if so, what type of Specialist Physician), a GP, a hospitalist, or other (if so, please specify).

Please specify.

5. (Note: Only for FFS Specialists) The Complex Care Discharge Planning Fee is $75.00. How would you rate the appropriateness of this fee level?

(On a scale of 1 to 5, where 1 is not at all appropriate, 3 is somewhat appropriate and 5 is very appropriate.)

1 – Not at all appropriate	2	3 – Somewhat appropriate	4	5 – Very appropriate	Don't Know

Please explain.

6. How likely are you to claim/bill the Complex Care Discharge Planning Fee in the future?

(On a scale of 1 to 5, where 1 is very unlikely, 3 is somewhat likely and 5 is very likely.)

1 – Very unlikely	2	3 – Somewhat likely	4	5 – Very likely	Don't Know

Please explain.

7. **Do you have any other recommendations for how Complex Care Discharge Planning could be improved?**

Please explain.

IMPACTS AND USEFULNESS OF FEE

8. **Please indicate your level of agreement with each of the following statements regarding the Complex Care Discharge Planning initiative.**

(On a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree, please specify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.)

The Complex Care Discharge Planning initiative...		Scale					
		1	2	3	4	5	Don't Know
a	Positively impacts work and collaboration with other healthcare providers to develop and implement more efficient patient care pathways	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
b	Supports the continuity of care and clinical coordination of complicated patients that require community support upon discharge	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
c	Improves patient care	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
d	Improves patient outcomes	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know

The Complex Care Discharge Planning initiative...		Scale					
		1	2	3	4	5	Don't Know
Please elaborate.							
e	Reduces complicated patients' risks of re-admission	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
f	Is necessary	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							

9. **Are you aware of any unexpected results (either positive or negative) that arose from the Complex Care Discharge Planning initiative?**

10. **Do you have any suggestions regarding how the Complex Care Discharge Planning Fee could be improved or further developed to realize even better results in the future?**

11. **Do you have any final comments?**

FUTURE SSC COMMUNICATION

12. **What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Complex Care Discharge Planning Fee?** *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website

- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

13. The SSC has approved a new work plan that will guide its activities for the upcoming year, which builds on the successes of existing initiatives and will introduce new complementary and integrated initiatives designed to improve Specialist engagement and coordination between physicians and the health authorities; support Specialists to deliver timely and valued patient care; and support the pursuit of quality and innovation in the health system.

Please rate the level of your personal interest in participating in each of these potential SSC-funded activities.

(On a scale of 1 to 5, where 1 means not at all interested and 5 means very interested)

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
a	Participate in training opportunities in physician leadership.	1	2	3	4	5	Don't Know
b	Participate in training opportunities to gain quality improvement skills	1	2	3	4	5	Don't Know
c	Participate in clinical skills enhancement opportunities.	1	2	3	4	5	Don't Know
d	Provide clinical skills support to your peers.	1	2	3	4	5	Don't Know
e	Lead or participate in a project or initiative that aims to improve population health, patient outcomes and experience, and potentially reduce/limit cost of care.	1	2	3	4	5	Don't Know
f	Receive time-limited quality improvement support which could include project management, data analysis or quality improvement support to help train and guide you to implement and measure changes.	1	2	3	4	5	Don't Know
g	Obtain time-limited funding or resources to support multidisciplinary care to help you implement changes to the way care is delivered or coordinated for your patients.	1	2	3	4	5	Don't Know
h	Other ideas (please specify)						

14. Would you like to be entered in the contest to win an iPad?

- ☐ Yes
- ☐ No

15. **(If yes) MNP will conduct the draw and will inform the Doctors of BC of the winner. The Doctors of BC will then contact the winner. This information is not tied to your survey responses and the Doctors of BC will not know your individual responses. Please enter your contact information below:**

    Name: _____

    Contact number: _____

That completes our survey. Thank you very much for your participation and input

GROUP MEDICAL VISIT FEES FOR SPECIALISTS INTERVIEW GUIDE

INTRODUCTION

Good morning/afternoon/evening. I am calling from MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). MNP, a Chartered Accounting and Advisory Services firm, has been engaged by the SSC to conduct a final evaluation of six SSC initiatives, including the Group Medical Visit Fees for Specialists.

We received your contact information from the SSC. As part of the evaluation, we are conducting interviews with Specialist Physicians that have trained for Group Medical Visits. The survey results will be used to assist in assessing the relevance and performance of the Group Medical Visit Fees for Specialists and determining whether the initiative has achieved its overall intended goals and objectives to date.

Do you have about 20 to 30 minutes right now to answer some questions? If not, we can schedule an interview for another time.

I should also note that, upon interview completion and with your consent, you will be entered into **a draw for a chance to win an iPad**. A representative from the Doctors of BC will contact you if your name has been drawn.

CONTACT INFORMATION

Name:	
Phone Number:	
Date:	

CLASSIFICATION QUESTIONS

To start, I would like to ask you a few questions for classification purposes.

PLEASE NOTE THAT THE INTERVIEWER WILL AIM TO COMPLETE THIS SECTION AHEAD OF THE INTERVIEW.

What is your specialty?

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ Chest Surgery
- ☐ Critical Care
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Internal Medicine
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Haematology & Oncology
- ☐ Infectious Diseases
- ☐ Medical Microbiology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics & Gynaecology
- ☐ Ophthalmology
- ☐ Orthopaedic Surgery
- ☐ Otolaryngology
- ☐ Paediatrics
- ☐ Pathology
- ☐ Physical Medicine
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Radiology
- ☐ Respirology
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other (please specify _____)

How many years have you been practicing as a Specialist Physician?

- ☐ Less than 1 year
- ☐ 1 to 3 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ 10 to 15 years
- ☐ Over 15 years

Which of the following best describes your practice?

- ☐ Primarily hospital-based
- ☐ Primarily community-based
- ☐ Other (please specify _____)

In what health authority do you practice most often?

- ☐ Fraser Health Authority
- ☐ Interior Health Authority
- ☐ Vancouver Island Health Authority
- ☐ Northern Health Authority
- ☐ Vancouver Coastal Health Authority
- ☐ Provincial Health Services Authority

Are you currently compensated on a fee-for-service basis through the Medical Services Plan or through Alternative Payment arrangements?

- ☐ Fee-for-service
- ☐ Alternative Payment arrangements

FAMILIARITY WITH THE FEE

1. **How did you come to know about the Group Medical Visit Fees for Specialists (e.g. e-news, President's letter, MSP newsletter, SSPS newsletter, BC Medical Journal, online search, colleagues, etc.)?**

   Please specify.

UTILIZATION OF FEE

2. **Have you completed/graduated from the Group Medical Visits module you participated in?**

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

IF RESPONDENT ANSWERED "NO" OR "DON'T KNOW", PROCEED TO QUESTION 2A.

IF RESPONDENT ANSWERED "YES", SKIP TO QUESTION 3.

2a. (If no) What are the main reasons why you have not yet completed the Group Medical Visits module?

Please explain.

3. **Have you ever billed/claimed the Group Medical Visits Fees for Specialists (Fee Code: G78763-81)?**

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

4. **Are Group Medical Visits currently a regular part of your practice?**

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

IF RESPONDENT ANSWERED "YES", PROCEED TO QUESTION 4A.

IF RESPONDENT ANSWERED "NO" OR "DON'T KNOW", SKIP TO QUESTION 4D.

4a. (If yes) How often, on average, per year are Group Medical Visits offered in your practice?

Please explain.

4b. In your opinion, what key characteristics, elements and/or supports make the Group Medical Visits concept effective for your practice?

Please explain.

4c. Please provide an example (or examples) of how you utilize Group Medical Visits in your practice. More specifically, please describe:

- An average, how many patients typically participate in a Group Medical Visit?
- What types of patients (with the same or similar chronic care conditions) typically attend Group Medical Visits?
- What, if any, allied health professionals (e.g. dieticians, pharmacists, physiotherapists, nurses) are involved? How are they compensated?
- Are other Specialist Physicians involved? *(Note for interviewer: Some Specialists need to do physical assessments during Group Medical Visits, which require 2 physicians to participate.)*
- Do you have dedicated Medical Office Assistants to help coordinate and organize the Group Medical Visits (i.e. to assist with ending out invitations, follow-up with patients, book locations, have patients sign confidentiality agreements, order refreshments, help run the meeting etc.)? If no, what, if any, support for coordinating Group Medical Visits do you currently receive?
- Where are Group Medical Visits typically held? Is it difficult finding suitable space for conducting Group Medical Visits? Does the location require you and your staff to travel?
- Do you spend one-on-one time with each patient during a Group Medical Visit? *(Note for interviewer: Service is not payable with other services, for the same patient, on the same day.)*

4d. (If no) What are the main reasons why you have not implemented Group Medical Visits in your practice (e.g. allied health professional support is not consistently available, lack of dedicated Medical Office Assistant support, difficulty findings suitable space, etc.)?

Please explain.

5. **In your opinion, what types of patient conditions, programs and/or services are suitable for Group Medical Visits?**

   Please explain.

6. **In your opinion, what are the most appropriate specialties for targeting Group Medical Visits?**

   Please explain.

APPROPRIATENESS OF FEE LEVEL

7. **The fee structure for Group Medical Visits for Specialists depends on the number of patients involved (i.e. the fee decreases as the size of the patient group increases) and ranges from $31.44 and goes down to $8.67. How would you rate the appropriateness of this fee level?**

(NOTE FOR INTERVIEWER: THE SPECIFIC FEE STRUCTURE FOR GROUP MEDICAL VISITS FOR SPECIALISTS IS OUTLINED BELOW.)

Specialist Group Medical Visits

Referred Cases

		Total Fee $
Fee per patient, per 1/2 hour		
G78763	Three patients	31.44
G78764	Four patients	25.41
G78765	Five patients	21.83
G78766	Six patients	19.42
G78767	Seven patients	17.72
G78768	Eight patients	16.44
G78769	Nine patients	15.43
G78770	Ten patients	14.60
G78771	Eleven patients	12.79
G78772	Twelve patients	12.03
G78773	Thirteen patients	11.14
G78774	Fourteen patients	10.94
G78775	Fifteen patients	10.50
G78776	Sixteen patients	10.18
G78777	Seventeen patients	9.76
G78778	Eighteen patients	9.54
G78779	Nineteen patients	9.20
G78780	Twenty patients	8.98
G78781	Greater than 20 patients (per patient)	8.67

(On a scale of 1 to 5, where 1 is not at all appropriate, 3 is somewhat appropriate and 5 is very appropriate.)

1 – Not at all appropriate	2	3 – Somewhat appropriate	4	5 – Very appropriate	Don't Know

Please explain.

8. **How likely are you to claim/bill the Group Medical Visits Fee for Specialists in the future?**

(On a scale of 1 to 5, where 1 is very unlikely, 3 is somewhat likely and 5 is very likely.)

1 – Very unlikely	2	3 – Somewhat likely	4	5 – Very likely	Don't Know

Please explain.

IMPACTS AND USEFULNESS OF FEE

9. Please indicate your level of agreement with each of the following statements regarding Group Medical Visits Fees for Specialists.

(On a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree, please specify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.)

The Group Medical Visits Fees for Specialists...		Scale					
		1	2	3	4	5	Don't Know
a	Are time efficient and reduce the need for Specialists to repeat the same information many times, thus freeing up time for other patients	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
b	Improve patient access to care	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
c	Support continuity of care for patients	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
d	Enhance collaboration between various allied health professionals (e.g. dieticians, pharmacists, physiotherapists, nurses)	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							

10. From your perspective, are you aware of any unexpected results (either positive or negative) that arose from the Group Medical Visit Fees for Specialists?

Please explain.

11. Do you have any suggestions regarding how the Group Medical Visit Fees or supports for Specialists could be improved or further developed (e.g. self-directed study such as online

modules, learning with other Specialists in a group setting, etc.) to realize even better results in the future?

12. Do you have any final comments?

FUTURE SSC COMMUNICATION

13. What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Group Medical Visit Fees for Specialists? *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website
- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

14. The SSC has approved a new work plan that will guide its activities for the upcoming year, which builds on the successes of existing initiatives and will introduce new complementary and integrated initiatives designed to improve Specialist engagement and coordination between physicians and the health authorities; support Specialists to deliver timely and valued patient care; and support the pursuit of quality and innovation in the health system.

Please rate the level of your personal interest in participating in each of these potential SSC-funded activities.

(On a scale of 1 to 5, where 1 means not at all interested and 5 means very interested)

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
a	Participate in training opportunities in physician leadership.	1	2	3	4	5	Don't Know

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
b	Participate in training opportunities to gain quality improvement skills	1	2	3	4	5	Don't Know
c	Participate in clinical skills enhancement opportunities.	1	2	3	4	5	Don't Know
d	Provide clinical skills support to your peers.	1	2	3	4	5	Don't Know
e	Lead or participate in a project or initiative that aims to improve population health, patient outcomes and experience, and potentially reduce/limit cost of care.	1	2	3	4	5	Don't Know
f	Receive time-limited quality improvement support which could include project management, data analysis or quality improvement support to help train and guide you to implement and measure changes.	1	2	3	4	5	Don't Know
g	Obtain time-limited funding or resources to support multidisciplinary care to help you implement changes to the way care is delivered or coordinated for your patients.	1	2	3	4	5	Don't Know
h	Other ideas (please specify)						

15. Would you like to be entered in the contest to win an iPad?

- ☐ Yes
- ☐ No

16. (If yes) MNP will conduct the draw and will inform the Doctors of BC of the winner. The Doctors of BC will then contact the winner. This information is not tied to your survey responses and the Doctors of BC will not know your individual responses. Please enter your contact information below:

Name: _____

Contact number: _____

That completes our survey. Thank you very much for your participation and input.

LABOUR MARKET ADJUSTMENTS INTERVIEW GUIDE

INTRODUCTION

Good morning/afternoon/evening. I am calling from MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). MNP, a Chartered Accounting and Advisory Services firm, has been engaged by the SSC to conduct a final evaluation of six SSC initiatives, including the Labour Market Adjustment initiative.

We received your contact information from the SSC. As part of the evaluation, we are conducting interviews with Section Heads and their Economic Leads. The survey results will be used to assist in assessing the relevance and performance of the Labour Market Adjustment initiative and determining whether the initiative has achieved its overall intended goals and objectives to date.

Your participation is voluntary and all information collected will be treated as confidential.

Do you have about 30 minutes right now to answer some questions? If not, we can schedule an interview for another time.

CONTACT INFORMATION

Please note that MNP will aim to conduct interviews with Section Heads and their Economic Leads simultaneously. For Sections that do not have Economic Leads within their teams, MNP will ask the Section Heads to identify any other individuals that would be beneficial to speak with for the purposes of this evaluation.

	Section Head	Economic Lead
Name:		
Phone Number:		
Date:		
Section:	☐ Neurology ☐ Obstetrics and Gynecology ☐ Internal Medicine ☐ Anesthesia ☐ Geriatrics Medicine ☐ Rheumatology ☐ Respirology ☐ Endocrinology ☐ Infectious Disease	

FAMILIARITY AND INVOLVEMENT WITH THE INITIATIVE

1. **Overall, how familiar are you with the Labour Market Adjustment initiative?**

   (On a scale of 1 to 5, where 1 is not at all familiar, 3 is somewhat familiar and 5 is very familiar.)

1 – Not at all familiar	2	3 – Somewhat familiar	4	5 – Very familiar	Don't Know

IF RESPONDENT PROVIDED A RATING OF 2 OR HIGHER, DIRECT HIM/HER TO QUESTION 2.

IF RESPONDENT IS "NOT AT ALL FAMILIAR", DIRECT HIM/HER TO A DESCRIPTION OF THE INITIATIVE (SEE DESCRIPTION IN TEXT BOX BELOW) AND SKIP TO THE "FUTURE SSC COMMUNICATION" SECTION OF THE QUESTIONNAIRE (IF STILL UNFAMILIAR).

As of fiscal year 2012/13, approximately $10 million has been awarded to nine sections to implement Labour Market Adjustment (LMA) Fee Items. The LMA Fund, allocated to specific Sections by the SSC to address labour market adjustments linked to recruitment and retention pressures, was based on the recommendations of an independent Labour Market Adjustment Advisory Committee. A total of 43 new fee codes were created and implemented during the summer of 2011.

For additional information on the Labour Market Adjustment process, please visit: https://www.bcma.org/committee/specialist-services-committee-ssc

2. W

SATISFACTION WITH THE PROCESS

Approximately $10 million has been awarded to nine Sections as of fiscal year 2012/13 to implement Labour Market Adjustment (LMA) Fee Items. The LMA Fund, allocated to specific Sections by the SSC to address labour market adjustments linked to recruitment and retention pressures, was based on the recommendations of an independent Labour Market Adjustment Advisory Committee. A total of 43 new fee codes were created and implemented during the summer of 2011.

3. In your opinion, was this initiative an appropriate response to address labour market adjustments linked to recruitment and retention pressures?

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please explain.

4. How satisfied are you regarding the overall process implemented by the Specialist Services Committee (including the readjustments made post Labour Market Adjustment funding as some Sections had over/under spent their allocations) **to address labour market adjustments linked to recruitment and retention pressures?**

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all satisfied	2	3 – Somewhat satisfied	4	5 – Very satisfied	Don't Know

Please explain.

5. How satisfied are you with the review panel process that was implemented? *(Note for interviewer: An independent panel was created in June 2010 to review submissions from sections interested in receiving funds for new fees as part of the labour market exercise.)*

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all	2	3 – Somewhat	4	5 – Very	Don't

satisfied		satisfied		satisfied	Know

Please explain.

6. **How would you rate the appropriateness of funding allocations to your Section?**

   (On a scale of 1 to 5, where 1 is not at all appropriate, 3 is somewhat appropriate and 5 is very appropriate.)

1 – Not at all appropriate	2	3 – Somewhat appropriate	4	5 – Very appropriate	Don't Know

Please explain.

7. **Are you aware of the utilization of new fees implemented through the labour market adjustment process (i.e. what Sections' new fees were over and/or underutilized)?**

   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

   Please explain.

(PLEASE NOTE THAT THE INTERVIEWER WILL BE FAMILIAR WITH WHAT SECTIONS UNDER AND OVER-UTILIZED THEIR FEE CODES BEFORE THE INTERVIEW.)

8. **I understand that your Section under/over-utilized the new fee codes that were created and implemented as a result of the labour market adjustment process. In retrospect, what (if any) changes would you make regarding:**

   a. **How funding was applied?**

   b. **How adjustments were made for your Section?**

EFFECTS OF LMAS ON RECRUITMENT AND RETENTION

9. **How successful was this initiative in addressing labour market adjustments linked to recruitment and retention pressures?** In other words, have the allocations established new fees or initiatives that help support the delivery of physician services?

   (On a scale of 1 to 5, where 1 is not at all successful, 3 is somewhat successful and 5 is very successful.)

1 – Not at all successful	2	3 – Somewhat successful	4	5 – Very successful	Don't Know

Please explain.

10. **What factors have <u>contributed to</u> making the Labour Market Adjustment Funding process a positive experience for the respective parties involved?**

    Please explain.

11. **What, if any, factors have <u>constrained</u> the success of the Labour Market Adjustment Funding process? In other words, have any factors negatively impacted the experiences of the respective parties involved in the process?**

    Please explain.

OTHER IMPACTS AND EFFECTS

12. **What have been the effects of the Labour Market Adjustment Funding initiative on the Section you represent?**

    Please explain.

13. **Which of your new fees do you believe have been most successful for your Section and could support other types of Sections?**

    Please explain.

14. **Do you have any suggestions regarding how the Labour Market Adjustment Funding process could be improved or further developed to realize even better results in the future?**

    Please explain.

15. **In your opinion, are there any other specific fees that would help address recruitment and retention pressures, should additional funding for Labour Market Adjustments be made available in the future?**

    Please explain.

16. **Do you have any final comments?**

FUTURE SSC COMMUNICATION

17. **What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Labour Market Adjustment Funding initiative?** *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website
- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

18. **The SSC has approved a new work plan that will guide its activities for the upcoming year, which builds on the successes of existing initiatives and will introduce new complementary and integrated initiatives designed to improve Specialist engagement and coordination between physicians and the health authorities; support Specialists to deliver timely and valued patient care; and support the pursuit of quality and innovation in the health system.**

Please rate the level of your personal interest in participating in each of these potential SSC-funded activities.

(On a scale of 1 to 5, where 1 means not at all interested and 5 means very interested)

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
a	Participate in training opportunities in physician leadership.	1	2	3	4	5	Don't Know
b	Participate in training opportunities to gain quality improvement skills	1	2	3	4	5	Don't Know

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
c	Participate in clinical skills enhancement opportunities.	1	2	3	4	5	Don't Know
d	Provide clinical skills support to your peers.	1	2	3	4	5	Don't Know
e	Lead or participate in a project or initiative that aims to improve population health, patient outcomes and experience, and potentially reduce/limit cost of care.	1	2	3	4	5	Don't Know
f	Receive time-limited quality improvement support which could include project management, data analysis or quality improvement support to help train and guide you to implement and measure changes.	1	2	3	4	5	Don't Know
g	Obtain time-limited funding or resources to support multidisciplinary care to help you implement changes to the way care is delivered or coordinated for your patients.	1	2	3	4	5	Don't Know
h	Other ideas (please specify)						

That completes our survey. Thank you very much for your participation and input.

HEALTH AUTHORITY REDESIGN FUNDING INTERVIEW GUIDE (FOR SPECIALIST PHYSICIANS)

INTRODUCTION

Good morning/afternoon/evening. I am calling from MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). MNP, a Chartered Accounting and Advisory Services firm, has been engaged by the SSC to conduct a final evaluation of six SSC initiatives, including the Health Authority Redesign Funding initiative.

We received your contact information from the SSC. As part of the evaluation, we are conducting interviews with Health Authority Representatives and Specialist Physicians that have partaken in this initiative. The survey results will be used to assist in assessing the relevance and performance of the Health Authority Redesign Funding initiative and determining whether the initiative has achieved its overall intended goals and objectives to date.

Do you have about 20 to 30 minutes right now to answer some questions? If not, we can schedule an interview for another time.

I should also note that, upon interview completion and with your consent, you will be entered into **a draw for a chance to win an iPad**. A representative from the Doctors of BC will contact you if your name has been drawn.

CONTACT INFORMATION

Name:	
Phone Number:	
Date:	

CLASSIFICATION QUESTIONS

To start, I would like to ask you a few questions for classification purposes.

PLEASE NOTE THAT THE INTERVIEWER WILL AIM TO COMPLETE THIS SECTION AHEAD OF THE INTERVIEW.

What is your specialty?

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ Chest Surgery
- ☐ Critical Care
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Internal Medicine
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Haematology & Oncology
- ☐ Infectious Diseases
- ☐ Medical Microbiology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics & Gynaecology
- ☐ Ophthalmology
- ☐ Orthopaedic Surgery
- ☐ Otolaryngology
- ☐ Paediatrics
- ☐ Pathology
- ☐ Physical Medicine
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Radiology
- ☐ Respirology
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other (please specify _____)

How many years have you been practicing as a Specialist Physician?

- ☐ Less than 1 year
- ☐ 1 to 3 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ 10 to 15 years
- ☐ Over 15 years

Which of the following best describes your practice?

- ☐ Primarily hospital-based
- ☐ Primarily community-based
- ☐ Other (please specify _____)

In what health authority do you practice most often?

- ☐ Fraser Health Authority
- ☐ Interior Health Authority
- ☐ Vancouver Island Health Authority
- ☐ Northern Health Authority
- ☐ Vancouver Coastal Health Authority
- ☐ Provincial Health Services Authority

INVOLVEMENT WITH THE INITIATIVE

1. **How did you come to know about the Health Authority Redesign Funding initiative?**

   - ☐ E-news
   - ☐ President's letter
   - ☐ MSP newsletter

- ☐ SSPS newsletter
- ☐ BC Medical Journal
- ☐ Online search
- ☐ Colleagues
- ☐ I was approached by my Health Authority
- ☐ Other (please specify _____)

2. **What types of Health Authority Redesign funded projects have you been involved in through your Health Authority** (i.e. system redesign initiatives such as Lean analysis, program development, special projects, etc.)**? Please list and describe specific projects.**

   Note for interviewer: For each project the Specialist Physician was involved in, please obtain information regarding project scope; timelines; amount of funding; goals; and outcomes.

3. **How likely are you to participate in the Health Authority Redesign Funding initiative again in the future?**

   (On a scale of 1 to 5, where 1 is very unlikely, 3 is somewhat likely and 5 is very likely.)

1 – Very unlikely	2	3 – Somewhat likely	4	5 – Very likely	Don't Know

Please explain.

4. **Based on your experience, do you know of any physicians that chose not to participate in this initiative?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

(If yes) Do you know of the reasons why they chose not to participate in this initiative?

SATISFACTION WITH PROCESS

5. **From your perspective, how effective is the Health Authority Redesign Funding initiative in bringing together Specialist Physicians and Health Authorities to improve the delivery of Specialist physician services?**

   (On a scale of 1 to 5, where 1 is not at all effective, 3 is somewhat effective and 5 is very effective.)

1 – Not at all effective	2	3 – Somewhat effective	4	5 – Very effective	Don't Know

Please explain.

6. **Overall, how satisfied are you with the Health Authority Redesign Funding project(s) outcomes that you participated in?**

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all satisfied	2	3 – Somewhat satisfied	4	5 – Very satisfied	Don't Know

Please explain.

7. **How satisfied are you with the process by which you were engaged in the Health Authority Redesign initiative by your respective health authority?**

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all satisfied	2	3 – Somewhat satisfied	4	5 – Very satisfied	Don't Know

Please explain.

8. **Overall, do you feel that your input to these health system improvement initiatives was valued by your respective Health Authority?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please explain.

9. **Did you experience any barriers to participation in this initiative? Please explain.**

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please explain.

10. **How satisfied are you with the reimbursement process through your respective Health Authority? More specifically, please rate your satisfaction with:**

(On a scale of 1 to 5, where 1 means not at all satisfied and 5 means very satisfied)

Satisfaction with the reimbursement process		Scale					
		Not at all satisfied	2	3	4	Very satisfied	Don't Know
a	The ease of this process	1	2	3	4	5	Don't Know

Satisfaction with the reimbursement process		Scale					
		Not at all satisfied	2	3	4	Very satisfied	Don't Know
	Please explain.						
b	The timeliness of reimbursement	1	2	3	4	5	Don't Know
	Please explain.						

IMPACTS AND EFFECTS OF INITIATIVE

11. Overall, how satisfied are you with the outcomes of the Health Authority Redesign funded project(s) that you were involved in through your Health Authority?

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all satisfied	2	3 – Somewhat satisfied	4	5 – Very satisfied	Don't Know

Please explain.

12. Please indicate your level of agreement with each of the following statements regarding the Health Authority Redesign Funding initiative.

(On a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree, please specify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements)

The Health Authority Redesign Funding initiative…		Scale					
		1	2	3	4	5	Don't Know
a	Increases Specialist Physician engagement with health service delivery planning	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
b	Increases collaboration between Specialist Physicians and Health Authorities	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							

The Health Authority Redesign Funding initiative…		Scale					
		1	2	3	4	5	Don't Know
c	Increases collaboration between Specialist Physicians and physician colleagues also involved in Health Authority Redesign planning	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
d	Improves the quality of health service delivery	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							

13. **What factors have <u>contributed to</u> making the Health Authority Redesign Funding initiative a positive experience for you?**

14. **What, if any, factors have <u>constrained</u> the success of the Health Authority Redesign Funding initiative? In other words, what, if any, factors have negatively impacted your experience with the initiative?**

15. **From your perspective, are you aware of any unexpected results (either positive or negative) that arose from the Health Authority Redesign Funding initiative?**

16. **What lessons have been learned through your involvement in this initiative that could improve future collaboration between Specialist Physicians and Health Authority representatives?**

17. **Do you have any final comments or recommendations?**

FUTURE SSC COMMUNICATION

18. **What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Health Authority Redesign Funding initiative?** *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website
- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

19. **The SSC has approved a new work plan that will guide its activities for the upcoming year, which builds on the successes of existing initiatives and will introduce new complementary and integrated initiatives designed to improve Specialist engagement and coordination between physicians and the health authorities; support Specialists to deliver timely and valued patient care; and support the pursuit of quality and innovation in the health system.**

Please rate the level of your personal interest in participating in each of these potential SSC-funded activities.

(On a scale of 1 to 5, where 1 means not at all interested and 5 means very interested)

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
a	Participate in training opportunities in physician leadership.	1	2	3	4	5	Don't Know
b	Participate in training opportunities to gain quality improvement skills	1	2	3	4	5	Don't Know
c	Participate in clinical skills enhancement opportunities.	1	2	3	4	5	Don't Know
d	Provide clinical skills support to your peers.	1	2	3	4	5	Don't Know
e	Lead or participate in a project or initiative that aims to improve population health, patient outcomes and experience, and potentially reduce/limit cost of care.	1	2	3	4	5	Don't Know

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
f	Receive time-limited quality improvement support which could include project management, data analysis or quality improvement support to help train and guide you to implement and measure changes.	1	2	3	4	5	Don't Know
g	Obtain time-limited funding or resources to support multidisciplinary care to help you implement changes to the way care is delivered or coordinated for your patients.	1	2	3	4	5	Don't Know
h	Other ideas (please specify)						

20. Would you like to be entered in the contest to win an iPad?

- ☐ Yes
- ☐ No

21. (If yes) MNP will conduct the draw and will inform the Doctors of BC of the winner. The Doctors of BC will then contact the winner. This information is not tied to your survey responses and the Doctors of BC will not know your individual responses. Please enter your contact information below:

Name: _____

Contact number: _____

That completes our survey. Thank you very much for your participation and input.

PHYSICIAN SCHOLARSHIP FUNDING INTERVIEW GUIDE (FOR HEALTH AUTHORITY PROJECT LEADS)

INTRODUCTION

Good morning/afternoon/evening. I am calling from MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). MNP, a Chartered Accounting and Advisory Services firm, has been engaged by the SSC to conduct a final evaluation of six SSC initiatives, including the Health Authority Redesign Funding initiative.

We received your contact information from the SSC. As part of the evaluation, we are conducting interviews with Health Authority Representatives and Specialist Physicians that have partaken in this initiative. The survey results will be used to assist in assessing the relevance and performance of the Health Authority Redesign Funding initiative and determining whether the initiative has achieved its overall intended goals and objectives to date.

Do you have about 20 to 30 minutes right now to answer some questions? If not, we can schedule an interview for another time.

CONTACT INFORMATION

Name:	
Title:	
Health Authority:	☐ Fraser Health Authority ☐ Interior Health Authority ☐ Vancouver Island Health Authority ☐ Northern Health Authority ☐ Vancouver Coastal Health Authority ☐ Provincial Health Services Authority
Phone Number:	
Date:	

INVOLVEMENT WITH THE INITIATIVE

1. **What types of projects has your Health Authority implemented using funding from this initiative** (i.e. system redesign initiatives such as Lean analysis, program development, special projects, etc.)**? Please list and describe specific projects undertaken by your Health Authority.**

   Note for interviewer: For each project undertaken, please obtain information regarding project scope; timelines; amount of funding; goals; and outcomes.

2. **What strategies or processes have you employed to engage Specialist Physicians to participate using the Health Authority Redesign funding?**

2a. From your experience, what were the most and least effective strategies to engage Specialist Physicians to participate using the Health Authority Redesign funding?

3. **How likely are you to utilize the Health Authority Redesign initiative in the future?**

(On a scale of 1 to 5, where 1 is very unlikely, 3 is somewhat likely and 5 is very likely.)

1 – Very unlikely	2	3 – Somewhat likely	4	5 – Very likely	Don't Know

Please explain.

SATISFACTION WITH PROCESS

4. **Overall, how effective is the Health Authority Redesign Funding initiative in bringing together Specialist Physicians and Health Authorities to improve the delivery of care?**

(On a scale of 1 to 5, where 1 is not at all effective, 3 is somewhat effective and 5 is very effective.)

1 – Not at all effective	2	3 – Somewhat effective	4	5 – Very effective	Don't Know

Please explain.

5. **Overall, how satisfied are you with the Health Authority Redesign Funding project(s) that you participated in?**

(On a scale of 1 to 5, where 1 is not at all satisfied, 3 is somewhat satisfied and 5 is very satisfied.)

1 – Not at all satisfied	2	3 – Somewhat satisfied	4	5 – Very satisfied	Don't Know

Please explain.

IMPACTS AND EFFECTS OF INITIATIVE

6. **Please indicate your level of agreement with each of the following statements regarding the Health Authority Redesign Funding initiative.**

(On a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree, please specify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.)

The Health Authority Redesign Funding initiative…	Scale					
	1	2	3	4	5	Don't Know

The Health Authority Redesign Funding initiative…		Scale					
		1	2	3	4	5	Don't Know
a	Increases Specialist Physician engagement with health service delivery planning	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
b	Increases collaboration between Specialist Physicians and Health Authorities	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							
c	Improves the quality of health service delivery	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't Know
Please elaborate.							

7. **What factors have <u>contributed to</u> making the Health Authority Redesign Funding initiative a positive experience for you?**

8. **What, if any, factors have <u>constrained</u> the success of the Health Authority Redesign Funding initiative? In other words, what, if any, factors have negatively impacted your experience with the initiative?**

9. **From your experience, are you aware of any unexpected results (either positive or negative) that arose from the Health Authority Redesign Funding initiative?**

10. **What lessons have been learned through your involvement in this initiative that could improve future collaboration between Specialist Physicians and Health Authority representatives?**

11. **Do you have any suggestions regarding how the Health Authority Redesign Funding initiative could be improved or further developed to realize even better results in the future?**

12. **Do you have any final comments or recommendations?**

FUTURE SSC COMMUNICATION

13. **What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Health Authority Redesign Funding initiative?** *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website
- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

That completes our survey. Thank you very much for your participation and input.

SPECIALIST ADVANCED CARE PLANNING FEE SURVEY

ABOUT THE SURVEY

This survey is being conducted by MNP LLP (MNP) on behalf of the Specialist Services Committee (SSC). The survey is part of a final evaluation of six SSC initiatives, including the Specialist Advanced Care Planning Fee.

The survey results will be used to assist in assessing the relevance and performance of the Specialist Advanced Care Planning Fee and determining whether the initiative has achieved its overall intended goals and objectives to date.

Your participation is voluntary and all information collected will be treated as confidential.

Please complete the following survey **prior to June 30, 2014**. All completed surveys, received by MNP prior to June 30, 2014, will be entered into **a draw for a chance to win an iPad**. A representative from the Doctors of BC will contact you if your name has been drawn.

About MNP

MNP is one of the largest chartered accountancy and consulting firms in Canada, providing client-focused accounting, taxation and consulting advice. National in scope and local in focus, MNP has proudly served individuals and public and private companies for more than 65 years. For more information, visit www.mnp.ca

CLASSIFICATION QUESTIONS

The following questions are for classification purposes.

Are you male or female?

- ☐ Male
- ☐ Female

What is your specialty?

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ Chest Surgery
- ☐ Critical Care
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Internal Medicine
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Haematology & Oncology
- ☐ Infectious Diseases
- ☐ Medical Microbiology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics & Gynaecology
- ☐ Ophthalmology
- ☐ Orthopaedic Surgery
- ☐ Otolaryngology
- ☐ Paediatrics
- ☐ Pathology
- ☐ Physical Medicine
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Radiology
- ☐ Respirology
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other (please specify _____)

How many years have you been practicing as a Specialist Physician?

- ☐ Less than 1 year
- ☐ 1 to 3 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ 10 to 15 years
- ☐ Over 15 years

Which of the following best describes your practice?

- ☐ Primarily hospital-based
- ☐ Primarily community-based
- ☐ Other (please specify _____)

In what health authority do you practice most often?

- ☐ Fraser Health Authority
- ☐ Interior Health Authority
- ☐ Vancouver Island Health Authority
- ☐ Northern Health Authority
- ☐ Vancouver Coastal Health Authority
- ☐ Provincial Health Services Authority

INVOLVEMENT WITH THE INITIATIVE

1. **Have you ever facilitated an Advance Care Planning discussion and plan development for patients with a chronic medical illness or complex co-morbidities, and a deteriorating quality of life or end-stage disease state?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

IF "YES", PROCEED WITH QUESTION 1A.

IF "NO" OR "DON'T KNOW", SKIP TO QUESTION 2.

1a. (If yes) On average, how many times per month do you provide Advance Care Planning services to your patients?

- ☐ Less than once a month
- ☐ One to three times per month
- ☐ Four to six times per month
- ☐ Seven to nine times per month
- ☐ More than nine times per month
- ☐ Don't Know

2. **Which of the following, if any, online resources on how to initiate Advance Care Planning discussions with patients, and how patients can develop an Advance Care Plan, have you accessed?** *Please check all that apply.*

- ☐ An SSC advance care plan template form
- ☐ A Q&A video
- ☐ Provincial "My Voice" document
- ☐ Advanced Directives Primer booklet
- ☐ Prognostic Indicators handout
- ☐ Scripted questions handout
- ☐ End of Life Articles: Letting Go
- ☐ Other (Please Specify _____)
- ☐ None of the above

3. **Please rate your level of comfort around having Advanced Care Planning discussions with your patients.**

(On a scale of 1 to 5, where 1 is not at all comfortable, 3 is somewhat comfortable and 5 is very comfortable.)

1 – Not at all comfortable	2	3 – Somewhat comfortable	4	5 – Very comfortable	Don't Know

Please explain.

4. **Overall, how familiar are you with the Specialist Advanced Care Planning Fee?**

(On a scale of 1 to 5, where 1 is not at all familiar, 3 is somewhat familiar and 5 is very familiar.)

1 – Not at all familiar	2	3 – Somewhat familiar	4	5 – Very familiar	Don't Know

Advance Care Planning is when a capable adult thinks about, and discusses, their beliefs, values and wishes for future health care, in the event the adult becomes incapable of making such decisions in the future. The adult may have Advance Care Planning discussions with close family or trusted friends and health care providers. When an adult's wishes are written down, they become an Advance Care Plan.

This objective of this $40.00 fee is to facilitate a Specialist physician to have a discussion with the patient about Advance Care Planning based on the patient's beliefs, values and wishes for future health care.

For more information on this fee, please visit: http://www.sscbc.ca/fees/advance-care-planning

UTILIZATION OF FEE

5. Have you ever billed/claimed the Specialist Advanced Care Planning Fee (Fee code G78720)?

- ☐ Yes
- ☐ No
- ☐ Don't Know

IF "YES", PROCEED WITH QUESTION 5A.

IF "NO" OR "DON'T KNOW", SKIP TO QUESTION 5D.

5a. What types of supports (for example, Advanced Care Planning guides) would be beneficial in assisting you with Advanced Care Planning?

Please specify.

5b. What types of supports would be beneficial in assisting you with billing the Advanced Care Planning Fee?

Please specify.

5c. Do you have any other recommendations for how the Specialist Advanced Care Planning Fee could be improved?

Please explain.

5d. (If no) Please indicate the main reasons why you do not bill for this fee. *Please check all that apply.*

- ☐ The fee is not applicable to my practice/role/situation (Please elaborate _____).
- ☐ I am currently compensated through Alternative Payment arrangements (i.e. not on a fee-for-service basis) and therefore I cannot bill for this fee.
- ☐ The fee is not necessary (Please elaborate _____).
- ☐ It requires too much work/time to bill (Please elaborate _____).
- ☐ I am not familiar with the appropriate billing procedures.
- ☐ Someone (i.e. Medical Office Assistant) is billing on my behalf.
- ☐ The fee is too low.
- ☐ Other (Please specify _____).

IF RESPONDENT SAID "I AM CURRENTLY COMPENSATED THROUGH ALTERNATIVE PAYMENT ARRANGEMENTS (I.E. NOT ON A FEE-FOR-SERVICE BASIS) AND THEREFORE I CANNOT BILL FOR THIS FEE", SKIP TO QUESTION 8.

(IF RESPONDENT HAS NEVER BILLED THE FEE (I.E. SAID "NO" OR "DON'T KNOW" TO QUESTION 5), PROCEED TO QUESTION 6.)

6. **(Note: Only for FFS Specialists) The Specialist Advanced Care Planning Fee is $40.00. The fee is paid only to the Specialist Physician for Advance Care Planning discussions and plan development for patients with a chronic medical illness or complex co-morbidities, or end-stage disease state. How would you rate the appropriateness of this fee level?**

   (On a scale of 1 to 5, where 1 is not at all appropriate, 3 is somewhat appropriate and 5 is very appropriate.)

1 – Not at all appropriate	2	3 – Somewhat appropriate	4	5 – Very appropriate	Don't Know

Please explain.

7. **How likely are you to claim/bill the Specialist Advanced Care Planning Fee in the future?**

   (On a scale of 1 to 5, where 1 is very unlikely, 3 is somewhat likely and 5 is very likely.)

1 – Very unlikely	2	3 – Somewhat likely	4	5 – Very likely	Don't Know

Please explain.

IMPACTS AND USEFULNESS OF FEE

8. **Please indicate your level of agreement with each of the following statements regarding the Specialist Advanced Care Planning initiative.**

   (On a scale of 1 to 5, where 1 means strongly disagree and 5 means strongly agree, please specify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.)

The Specialist Advanced Care	Scale

Planning initiative...		1	2	3	4	5	Don't know
a	Enhances collaboration between the Specialist Physician, the patient and the patient's primary health care provider	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't know
Please elaborate.							
b	Enables improved continuity and clinical coordination of care for patients with a chronic medical illness or complex co-morbidities or end-stage disease state	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't know
Please elaborate.							
c	Is useful in assisting with Advance Care Planning based on the patient's beliefs, values and wishes for future health care	Strongly Disagree	2	Neither agree nor disagree	4	Strongly agree	Don't know
Please elaborate.							

9. **Are you aware of any unexpected results (either positive or negative) that arose from the Specialist Advanced Care Planning initiative?**

10. **Do you have any suggestions regarding how the Specialist Advanced Care Planning Fee could be improved or further developed to realize even better results in the future?**

11. **Do you think that further training and/or resources should be offered to Specialist Physicians to learn about Advance Care Planning in more detail?**

    - ☐ Yes
    - ☐ No
    - ☐ Don't Know

    Please explain.

12. **Are you aware of the Practice Support Program's End of Life Module, available for physicians that wish to learn more about Advance Care Planning and end of life care?** (The End of Life

Module provides training for practitioners to improve care of patients and families living with, suffering and dying from life-limiting and chronic illnesses. Physicians learn how to identify patients that could benefit from a palliative approach to care; increase confidence and communication skills to enable Advance Care Planning conversations; and improve collaboration with providers, patients, families and caregivers.)

- ☐ Yes
- ☐ No
- ☐ Don't Know

12a. (If yes) Have you used the Practice Support Program's End of Life Module?

- ☐ Yes
- ☐ No
- ☐ Don't Know

13. Do you have any final comments?

FUTURE SSC COMMUNICATION

14. What are the most effective ways the SSC can communicate with you on existing and future initiatives, such as the Specialist Advanced Care Planning Fee? *Please check all that apply.*

- ☐ E-news (email sent two times a month)
- ☐ President's letter
- ☐ MSP newsletter
- ☐ SSPS newsletter
- ☐ SSC quarterly newsletter
- ☐ BC Medical Journal
- ☐ Materials mailed or sent out in the BC Medical Journal
- ☐ Doctors of BC website
- ☐ SSC website
- ☐ Doctors of BC annual report
- ☐ 'The Specialist Consult'
- ☐ Face-to-face meetings
- ☐ Information sessions
- ☐ Forums
- ☐ Other (please specify _____)

15. The SSC has approved a new work plan that will guide its activities for the upcoming year, which builds on the successes of existing initiatives and will introduce new complementary and integrated initiatives designed to improve Specialist engagement and coordination between physicians and the health authorities; support Specialists to deliver timely and valued patient care; and support the pursuit of quality and innovation in the health system.

Please rate the level of your personal interest in participating in each of these potential SSC-funded activities.

(On a scale of 1 to 5, where 1 means not at all interested and 5 means very interested)

Interest in Participation		Scale					
		Not at all interested	2	3	4	Very interested	Don't Know
a	Participate in training opportunities in physician leadership.	1	2	3	4	5	Don't Know
b	Participate in training opportunities to gain quality improvement skills	1	2	3	4	5	Don't Know
c	Participate in clinical skills enhancement opportunities.	1	2	3	4	5	Don't Know
d	Provide clinical skills support to your peers.	1	2	3	4	5	Don't Know
e	Lead or participate in a project or initiative that aims to improve population health, patient outcomes and experience, and potentially reduce/limit cost of care.	1	2	3	4	5	Don't Know
f	Receive time-limited quality improvement support which could include project management, data analysis or quality improvement support to help train and guide you to implement and measure changes.	1	2	3	4	5	Don't Know
g	Obtain time-limited funding or resources to support multidisciplinary care to help you implement changes to the way care is delivered or coordinated for your patients.	1	2	3	4	5	Don't Know
h	Other ideas (please specify)						

16. Would you like to be entered in the contest to win an iPad?

- ☐ Yes
- ☐ No

17. (If yes) MNP will conduct the draw and will inform the Doctors of BC of the winner. The Doctors of BC will then contact the winner. This information is not tied to your survey responses and the Doctors of BC will not know your individual responses. Please enter your contact information below:

Name: _____

Contact number: _____

That completes our survey. Thank you very much for your participation and input.

APPENDIX B – FEE CODES CREATED AND IMPLEMENTED THROUGH LMA FUNDING

Anesthesiology		
G01195	Minimum Anesthetic Procedural Fee	102.50
Endocrinology		
G33260	Initial virtual consult	110.00
G33262	Repeat or limited virtual consult	55.00
G33267	Virtual follow-up visit	35.00
G33250	Virtual communication between Specialist and patient	10.00
G33255	Insulin start	40.00
G33256	Insulin pump	80.00
G33240	Age 75+ premium for consults	52.66
G33241	Age 75+ for visits & insulin starts	14.12
General Internal Medicine (CRIM)		
G32307	Subsequent follow-up office visit, complex	125.00
G32308	Subsequent hospital visit, complex	125.00
G32317	Subsequent follow-up office visit, limited complex patient	50.00
G32318	Subsequent hospital visit, limited complex patient	70.00
G32312	Limited complex consult	195.00
Geriatric Medicine		
G33445	Geriatric Care Conference	47.50
G33450	Family Conference	42.50
G33455	Geriatric Reassessment 65-74	94.22
Infectious Diseases		
G33645	HIV/AIDs	98.76
G33650	Advice about patient in community	17.86
G33655	Home parenteral antibiotic management	23.91
Neurology		
G00468	Transcranial Doppler Ultrasound/ 15 min	115.99
G00469	Transcranial Doppler Ultrasound prolonged	$28.99 per 15 min
G00465	Acute stroke intra-arterial thrombolysis	1,047.98
G00457	Extended complex visit	35.73
G00450	Extended neurological consult complex	56.69
G00462	Clinical Interpretation submitted films	51.22
G00460	Extended consult transitional care (child to adult)	378.82
Obstetrics and Gynaecology		
G04701	Repeat urinary incontinence	407.05
G04702	Remove suburethral sling	407.05
G04703	Anterior vaginal vault repair with graft	405.96
G04704	Posterior vaginal vault repair with graft	405.96

G04705	Removal trans vaginal synthetic mesh	487.15
G04706	Vaginal vault suspension Apical	395.85
G04707	Laparoscopic Sacrocolpopexy	580.00
G04708	Prolonged Lap procedure	$70 per 15 min
G04709	Lap hysterectomy	843.29
G04710	Lap hysterectomy Certified Surgical Assist	$251.70 first hour
G04711	Lap hysterectomy Certified Surgical Assist after 1 hour	$26.28 per 15 min
G04712	Lap hysterectomy Surgical Assist after 3 hours	$27.33 per 15 min
G04713	Lap hysterectomy 2nd Surgical Assist	238.96
G04714	Prolonged open procedure	$70 per 15 min
G04715	Obstetrical surcharge abortion 18 weeks+	80.00
G04716	Obstetrical surcharge 14-18 weeks	60.00
G04717	Prenatal office visit complex	45.76
G04718	Care antepartum patient prior to transfer	273.77
G04719	Care of complex surgical patient 75+	62.50
Respirology		
G32011	Complex assessment, time-based for specific clinics	53.16
Rheumatology		
G31050	Rheumatology extended consult (exceed 61 min)	263.94
G31055	Annual immunosuppressant medication review	40.00
G31060	Multidisciplinary Consult for community-based patient	220.51
	Written advice about a patient (pending)	*40.00*

Source: Labour Market Adjustment Summary Document. August 2012

APPENDIX C – PERFORMANCE MONITORING DASHBOARD SAMPLE