SSC META-EVALUATION 2010-2021:

Fall 2021

A review of Triple Aim Impacts

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I've been able to do so much for my department, for my patients, for my co-workers. I've made really important changes in patient care."

Physician speaking of SSC supports

Executive summary

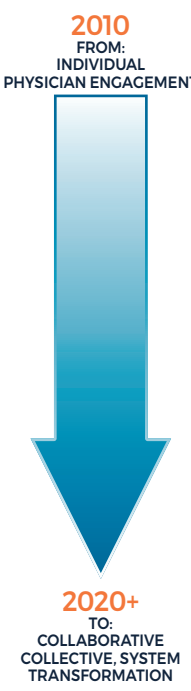
This evaluation examines the Specialist Services Committee's (SSC) Triple Aim impacts over the last 10 years. The evaluation, commissioned by SSC and conducted by a third party, uses a wide range of existing data sources including SSC's administrative documents, third party evaluation reports and physician project summaries. In addition, 22 interviews were conducted with physicians and SSC Committee members. The following is a summary of key findings.

SSC's strategic approach has evolved over time

SSC's strategic approach has evolved over time through deliberate and intentional continuous quality improvement. While SSC's early work was aimed at supporting physicians at the individual level, the work gradually moved to supporting physicians more centrally, more collectively and more collaboratively. SSC's current momentum is towards work that is increasingly systems focused.

SSC has implemented a broad set of initiatives that has reached thousands of physicians

Collectively, SSC initiatives have reached thousands of physicians, across specialty areas and across the province. SSC's initiatives work in tandem, each focussing on a core set of objectives that collectively aim to impact the triple aim. Surprisingly, despite a broad set of initiatives and a wide reach, some physicians across the province are not fully aware of SSC and its initiatives.



Major SSC Initiative	Active Years
SSC Fees	2010 – 2020
Labour Market Adjustment Fees (LMA)	2010 – 2020
Health System Redesign (HSR)	2010 – Current
Physician Leadership Scholarship (PLS)	2011 - Current
Quality and Innovation Fund (Q&I)	2012 – 2022
Physician Leadership Program (PLP)	2013 - Current
Facility Engagement Initiative (FEI)	2014 – Current
Physician Quality Improvement (PQI)	2014 – Current
Enhancing Access Initiative (EAI)	2018 – Current
Surgical Patient Optimization Collaborative (SPOC)	2019 – Current

Triple Aim Results

SSC has had a significant positive impact on Provider Experience

There is strong evidence of increased Provider Experience: ●●●●○

The body of evidence supporting SSC's impacts on Provider Experience is extensive. Through a variety of approaches, SSC has enabled thousands of physicians across the province to work with each other and the health care system. Many of SSC's impacts in this domain show deep and durable systemic change. Moreover, efforts to improve physician experience has enabled important improvements in the remainder of the *Triple Aim.*

Key evidence includes:

- Improved structures and supports that strengthen facility engagement
- Improved structures and supports that enable physicians to implement quality improvement
- Physicians have developed important leadership and quality improvement skills
- Physicians have implemented hundreds of quality improvement projects
- Physicians have contributed their voices to decisions that impact their work

SSC has had important impacts on Patient Experience and Population Health

There is moderately strong evidence of improved Patient Experience and Patient Health Outcomes: ●●●◐○

Several initiatives and hundreds of physician-led projects across SSC have worked to improve patient pathways of care including patient access and patient centeredness. Unfortunately, robust documentation on project outcomes was only sometimes available. As such the full extent of SSC's impacts in this area is not wholly known. Nonetheless, notable and substantial outcomes were achieved in a number of important domains which collectively have had important impacts on patient experience and population health.

Key evidence includes:

- Improved patient access and reduced wait times
- Implementation of pooled referral models, telehealth, and other best practices
- Improved patient care pathways including the pre and post surgical journey
- Improved patient centeredness and care pathways

SSC has had a positive impact on Per-Capita Cost of Healthcare

There is moderate evidence of reduced healthcare costs:●●●○○

The availability of evidence is more difficult with this last *Triple Aim*. Calculating healthcare related costs savings is excessively difficult and in a complex environment, there is a real danger in examining costs from a simplistic lens. As such, showing strong impacts in reducing the per capita cost of healthcare is not currently feasible. Even so, hundreds of SSC projects, implementing a wide range of strategies and mechanisms, have worked to improve healthcare costs.

Key evidence includes:

- Reduced length of stay through prehabilitation and improved surgical pathways
- Reduced patient costs including travel time and fuel costs as a result of telehealth service

Contents

Introduction

The Specialist Services Committee (SSC or the Committee) is one of four Joint Collaborative Committees (JCCs) formed in 2006 under the Physician Master Agreement (PMA[1]) to improve BC's health care system. The SSC is a partnership between Doctors of BC, the government of BC and representatives of the Health Authorities. The Committee is formally accountable to the Government of British Columbia and the Doctors of BC through the PMA. However, the Committee recognizes their additional accountability to patients and their families, physicians, and other healthcare system partners. In the spirit of continuous quality improvement, the SSC commissioned a third-party evaluation examining its *Triple Aim* impacts over the last approximately 10 years. This report is the result of that evaluation.

SSC's work is framed around the *Triple Aim*. The SSC, along with the other JCCs, has adopted a modified version of the Institute for Healthcare Improvement (IHI) *Triple Aim* that adds *provider experience* as a fourth aim. In BC, this approach is sometimes referred to as "the modified triple aim", "the quadruple aim" or simply the "triple aim". Consistent with other SSC documentation, this report uses the term *Triple Aim*.

Definitions for each of the four aims of the *Triple Aim* are provided below. They were adapted, in part, from IHI *Triple Aim*[2], the Canadian Institute for Health Information (CIHI)[3] and the JCC document entitled *Principles for the Joint Collaborative Committees*.[4]

Triple Aim Definitions:

Provider Experience	Physicians engaged to work with each other, the health care system (including other health care professionals), and their communities, to lead and/or support quality improvement and the spread of effective innovations and to improve their working environment in facilities.
Patient Experience	Ability to access coordinated and safe healthcare services that honours a person's choices, needs and values including cultural safety and humility.
Population Health	Health of the population including health conditions, health functioning and well being.
Per Capita Cost	Measure of the average cost of delivering healthcare per person.

1 The *Physician Master Agreement* is available here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/2019_physicia_master_agreement.pdf

2 Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

3 CIHI, *A Performance Measurement Framework for the Canadian Health System,* (2013). https://secure.cihi.ca/free_products/HSP-Framework-ENweb.pdf

4 *Principles for the Joint Collaborative Committees* can be found here: https://www.doctorsofbc.ca/sites/default/files/jcc_principles.pdf

Evaluation methods

The evaluation uses primarily secondary data sources including SSC administrative documents, third party evaluation reports and physician project summaries. The use of secondary data sources limits the evaluation in so much as the data did not always include robust evidence with which to assess impacts on the *Triple Aim*. This was particularly true at the project level. To supplement the secondary data, 22 interviews were conducted with physicians (n=16) and SSC Committee members (n=6). The evaluation was supported by an Evaluation Working Group that provided feedback on evaluations scope, methods and deliverables.

The evaluation uses primarily secondary data sources.

The evaluation uses primarily a retrospective design. That is, the evaluation examines data already collected by SSC in the form of existing evaluation reports and administrative documents created between 2010 and 2021. The number of documents examined was extensive (!) and included SSC bi-monthly meeting agenda packages (including attachments), SSC bi-monthly meeting minutes, SSC newsletters, SSC annual reports, evaluation reports, tracking spreadsheets and relevant project reports/slide decks. Documents on the SSC website were also reviewed. The only new information collected for the purposes of this evaluation was gathered through 22 semi-structured interviews with SSC committee members (n=6) and with physicians (n=16) who had participated in various SSC initiatives (e.g., Facility Engagement (FE), Physician Quality Improvement Initiation (PQI), Physician Leadership Program (PLP)). These interviews asked participants to reflect on SSC's work as a whole along with its impacts on the *Triple Aim*.

The evaluation was supported by an Evaluation Working Group

An evaluation working group was created to provide advice and feedback on the evaluation as it evolved. The working group provided feedback on evaluation scope, methods, and deliverables. It is important to note that the working group acted only as a sounding board – providing the evaluator with their thoughts and feedback on the approach and the deliverables. They did not influence the evaluation results or findings. The working group consisted of both SSC committee members (total 4: 2 Health Authority representatives, 1 Doctors of BC representatives and 1 guest) and SSC staff (n= 5). The group met a total of 5 times over the course of the evaluation.

Evaluation limitations

One of the disadvantages of a retrospective design examining primarily administrative data is that relevant information is not always readily available. In particular, SSC initiatives were not always explicitly and concretely linked to the *Triple Aim* in available documentation. While the connections to the *Triple Aim* could sometimes be inferred (e.g., improved physician engagement is evidence of improved provider experience), it was not always made explicit. This was especially

the case with older documents. As such, this required this evaluation to reconsider available data in light of the *Triple Aim* (i.e., retrofit).

Second, while many important activities contributing towards the *Triple Aim* occurs at the project level, there is relatively little robust documentation of outcomes at the project level. The work of SSC is complex and much of the work occurs on 2 distinct levels: at the initiative level and at the project level. SSC develops and implements initiatives in line with its strategic objectives (e.g., PQI training). These initiatives in turn often include physician projects as part of their implementation plans (e.g., Action Learning Projects). Most of SSC's administrative documents provide initiative-level information not project-level information. This, of course, is anticipated. SSC steers the goals, objectives, and implementation of SSC initiatives. It does not steer each individual physician project. As such, a preponderance of its administrative data is appropriately focused on the initiative level. Nonetheless, this presents a limitation for this evaluation. This dearth of robust data at the project level can lead to both over-estimation of impacts (e.g., in the case where positive project outcomes are taken at face value despite the lack of documented methodological rigour) or an under-estimation of impacts (e.g., in the case where positive outcomes are not readily evident in the documentation, despite their existence). The author considered the totality of the evidence along with its documented rigour when determining the overall strength of the evidence supporting *Triple Aim* outcomes, perhaps under-estimating impacts.

Results

SSC's strategic approach has developed and evolved over time

SSC's commitment to continuous quality improvement is evident in the evolution of their strategic focus over the last two decades. Their approach to impacting the *Triple Aim* has evolved considerably over time from a focus on engaging the individual physician to a collective, collaborative focus on system transformation.

The Early Years: SSC's early work was aimed at supporting physicians at the individual level.

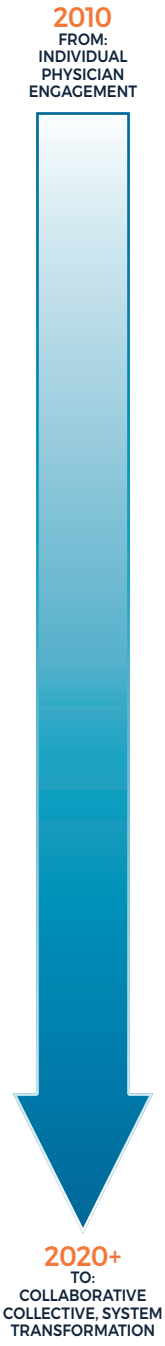
- Physicians were consulted on the creation and implementation of new fees that incentivize them to expedite access and improve care coordination (i.e., SSC fees and LMA fees)
- Health authorities have access to sessional fees that bring together physicians around specific discussion points (i.e., Health System Redesign)
- Physicians have access to scholarships to pay the cost of tuition for ad-hoc, external training (i.e., Scholarship Fund)
- Physician-led projects are funded through an open call for time-limited, specialist-led quality improvement projects (i.e., Quality and Innovation Fund)

More recently: SSC's work has moved to support physicians more centrally, more collectively and more collaboratively.

- Strengthening physicians' collective voice and engagement with HAs at the facility and regional levels is centrally supported (i.e., Facility Engagement Initiative)
- Physician quality improvement training is co-created through deep collaboration between health authorities and physicians (i.e., PQI)
- Physicians are centrally supported to implement quality improvement projects and initiatives (i.e., PQI, Enhanced Access, SPOC).
- System wide transformation is achieved through strategic, targeted, high priority, quality improvement initiatives (i.e., Enhanced Access, SPOC)

Current momentum: SSC's work is increasingly systems focused.

- Physician engagement that goes beyond hospitals and acute care facilities, to include community-based specialists and family physicians, is increasingly evident
- Engagement and collaboration that goes beyond individual facilities and individual regions is increasingly apparent
- System wide knowledge exchange and spread of quality improvement is increasingly prioritized



SSC's current strategic approach is one centered around 3 core strategies: Engaging physicians and health partners, developing physician capabilities and transforming care delivery.[5]

SSC has implemented a broad and deep set of initiatives that has reached thousands of physicians

SSC's initiatives have been broad and deep, reaching thousands of physicians across the province. While initiatives are individually successful, they also work in tandem producing results that go beyond each of the separate initiatives. Despite this success and SSC's efforts to increase its presence and outreach over time, there remain physicians unaware of SSC's mandate, strategies, and initiatives.

While a precise count of all physicians involved across all of SSC initiatives is not available, the data below shows the wide reach SSC has had within each initiative. The table also showcases

5 More information can be found here: https://sscbc.ca/what-we-do-you

the evolution of SSC's strategic approach as detailed above. While early efforts where primarily focussed on re-engaging the individual physician, more recent efforts are increasingly strategically 'systems' focussed. A detailed review of each of these initiatives is beyond the scope of this evaluation, interested readers should consult the footnotes for links to additional information including initiative level evaluations where available.

Major Initiative	Active Years	Total Reach
SSC Fees[6]	2010 – 2020	8 Fees created and implemented 3,173,888 total utilization between 2010 and 2020
Labour Market Adjustment Fees (LMA)[7]	2010 – 2020	43 Fees created and implemented (by 9 Specialty Sections) 1,843,208 total utilization between 2010 and 2020
Health System Redesign (HSR)[8]	2010 – Current	478 Health Authority Projects 4,901 physicians engaged (2,537 SPs[9] and 2,364 GPs[10])
Physician Leadership Scholarship (PLS)[11]	2011 - Current	1,559 Scholarships awarded 994 Physicians participated (643 SPs and 445 GPs)
Quality and Innovation Fund (Q&I)[12]	2012 – 2022[13]	2012: 19 Projects funded 2015: 31 Projects funded
Physician Leadership Program (PLP)[14]	2013 - Current	15 Cohorts graduated; 1 cohort underway 530 Physicians (362 Specialists, 105 GPs, 63 unknown)

6 SSC and LMA fees will be moved to the available amount in April 2022. More on SSC and LMA fees can be found here: https://sscbc.ca/fees

7 Ibid.

8 2021 data; More on SSC's Health System Redesign is a joint initiative with the Shared Care Committee and the General Practice Services Committee. More informationcan be found here: https://sscbc.ca/system-improvement/health-system-redesign

9 This report uses SPs as an abbreviation for the term "specialists"

10 This report uses GPs as an abbreviation for the term "general practitioners", and interchangeably with family physicians

11 2021 data; More information on the Physician Leadership Scholarship fund can be found here: https://sscbc.ca/physician-engagement/leadership-training-scholarship

12 2021 data; More information on the Quality and Innovation initiative can be found here: https://sscbc.ca/system-improvement/quality-and-innovation-initiative

13 Two projects have received an extension to March 2022 to complete their projects, after which the initiative will formally end.

14 2021 data; Physician Leadership Program (PLP; Sometimes colloquially referred to as Sauder). The 2019 evaluation can be found here: https://sscbc.ca/sites/default/files/PLP%20Evaluation%20Final%20Report_FINAL%20May%202019%20%282%29.pdf

Major Initiative	Active Years	Total Reach
Facility Engagement Initiative (FEI)[15]	2014 – Current	73 Medical Staff Associations (MSAs; + 2 in start-up) 7,140 members registered in FEMS[16] (including 7,128 physicians) 2,699 Projects registered in SEAT[17]
Physician Quality Improvement (PQI)[18]	2014 – Current	Level 1: 614 Physicians Level 2: 889 Physicians Level 3: 455 Physicians Level 3: 28 Cohorts completed or underway Level 3: 304 Action Learning Projects completed
Enhancing Access Initiative (EAI)[19]	2018 – Current	24 Specialist Teams 191 Specialists
Surgical Patient Optimization Collaborative (SPOC)[20]	2019 – Current	14 Multidisciplinary teams 145 Physicians, 99 specialists, 46 GPS 7,348 Patients screened

Many SSC initiatives and strategies work in tandem

Physician interviews reveal that many of SSC's strategies work in tandem, creating a sum that is greater than its parts. Speaking of PQI and PLP, one physician put it this way: *"It was after the combination of those two programs that I really felt like our ideas were able to take flight because we were able to advocate for them, execute them and situate them within the greater healthcare system".* Another physician shared "*But those two courses really helped me feel like I should be the one, that I'm not going to be happy unless I'm improving things for my coworkers and my patients, and it's given me the tools to do that. So, yeah, those were tremendously influential…. And facility engagement is definitely what is carrying me through now. Especially in the pandemic."*

15 The Facility Engagement Initiative was negotiated as part of the 2014 PMA but was formally launched in 2016. More information can be found here: https://facilityengagement.ca/

16 September 2021 data; from FEI's Facility Engagement Management System (FEMS).

17 September 20211 data; from FEI's Site Engagement Activity Tracker (SEAT)

18 2021 data; More information on PQI can be found here: https://sscbc.ca/physician-engagement/quality-improvement-initiative

19 2021 data; More information on Enhancing Access can be found here: https://sscbc.ca/programs-and-initiatives/transform-care-delivery/enhancing-access-initiative

20 2021 data; The Surgical Patient Optimization Collaborative (SPOC) is supported by SSC and the Shared Care Committee. More information can be found here: https://sscbc.ca/programs-and-initiatives/transform-care-delivery/surgical-patient-optimization-collaborative-spoc-0 ;

Many physicians are not fully aware of SSC and its initiatives, despite SSC's increased presence over time

Despite the high level of participation evident in the table above, many of the physicians interviewed for this evaluation did not have a full understanding of SSC. It is fair to say, that most had very limited knowledge of SSC. Some physicians where unclear on the distinction between SSC, SCC, JCCs, Specialists of BC and other acronyms with which the evaluator was unfamiliar.

> *"I guess I feel like a little silly that I don't really know, even after having taken advantage of so many of the programs, I still don't necessarily understand exactly who they are and who they're made up of and and …what they are trying to do." - Physician*

> *"I don't really know at all about their strategic plan or their mission or their overarching goal. I know they work with specialists in the province and quality improvement. But beyond that, I don't know." - Physician*

SSC has worked to increase its presence over time. A standalone website was developed in 2012 and periodically updated. That same year, 2 SSC articles appeared in the *BC Medical Journal*, with regular articles appearing after that. A newsletter was published starting in 2013. The following year, in 2014, SSC first participated as a presenter at the BC Quality Forum. Two years later, in 2016, the Joint Collaborative Committees (JCCs) held a collective forum as a one-day pre-event to the BC Quality forum which it continued every year until 2020 (when the COVID pandemic made it unfeasible to meet in-person). In 2018, the SSC project directory, The Exchange[21], was launched allowing interested physicians to search and find SSC funded projects. Also in 2018, SSC began producing committee meeting summaries, entitled *The Wrap*, and publishing them on their website. In 2019, a specialist symposium was held to engage specialists in the development of the SSC 2020-2023 strategic plan. The current SSC website is a repository of much of this material and includes a wide variety of information including the newsletter, the meeting summaries, initiative summaries, annual reports including some financial informations, evaluations, project stories and the Exchange – among other things. It can be found at www.sscbc.ca.

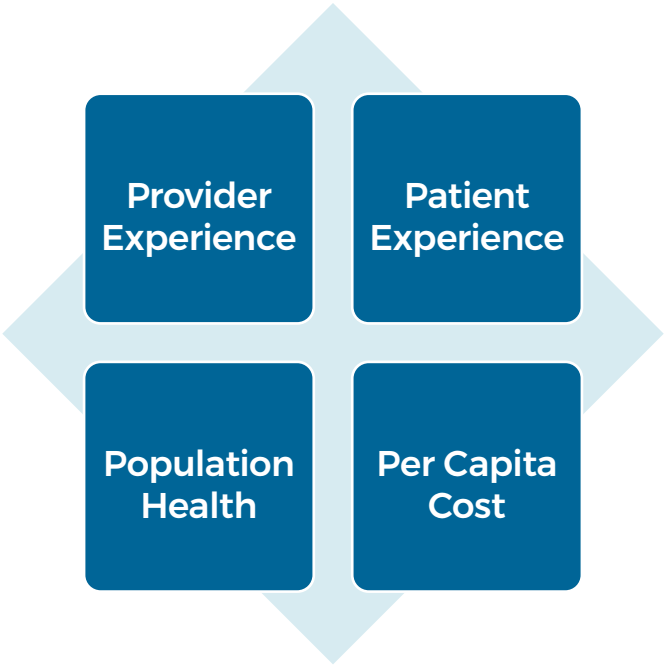
21 The Exchange is an online searchable database of quality improvement projects supported by SSC. Launched in 2018, it was created to facilitate the sharing of quality improvement ideas and project information. The database currently lists 1,592 quality improvement projects across 5 SSC initiatives. While not all SSC projects since 2010 are listed, it does provide an understanding of the volume of projects undertaken by physicians. In addition, each projects lists its key impacts among a list of 9 impacts. Note that while SCC projects are also listed in the database, they are excluded from all analyses in this report. The Exchange can be found here: https://sscbc.ca/projects-directory.

Despite the plenitude of available information, many physicians interviewed did not have a full understanding of SSC. Interestingly, some where not aware that they had participated in an SSC funded initiative and others were not aware of the link between SSC and the initiative in which they had participated. Below you can find a sample of quotes taken from interviews with 6 different physicians (out of the 16 interviewed for the evaluation).

> *"Can you tell me what I might have done with SSC? What did I participate in?" …"Oh okay. Yes, PQI. That was funded by SSC? Oh I thought that was paid by the health authority."*
>
> *"Oh I thought we were talking about Shared Care"*
>
> *"How is SSC linked to my section?"*
>
> *"Is FE SSC? I didn't know that."*
>
> *"I wish all the funding was more obvious and more transparent and that people told us about it. I've been volunteering for things that probably should have been paid"*
>
> *"I found out about Sauder completely by accident. It was a fluke."*

Triple Aim Results

The healthcare system is a complex system. It is important to remember that while the report is organized into distinct *Triple Aim* sections for ease of comprehension, there is considerable overlap and relationships between constructs. For example, a physician led quality improvement project aimed at improving a particular care pathway can simultaneously impact physician experience, patient experience, patient health outcomes and healthcare costs. Nonetheless, for ease of comprehension, it is helpful to look at each aim in turn and to align those interventions that have the greatest impact on that aim within the section.



SSC has had a significant positive impact on Provider Experience

There is strong evidence of increased *Provider Experience*.

Strength of the evidence: ●●●●○

The body of evidence supporting SSC's impacts on Provider Experience is extensive and confirms that SSC has had a significant impact on Provider Experience. SSC has improved Provider Experience through a broad range of mechanisms including through engagement structures and supports, quality improvement and leadership training and the implementation of physician-led quality improvement projects and initiatives. These approaches have engaged thousands of physicians across the province to work with each other and the health care system. Many of SSC's impacts show deep and durable systemic change, including robust engagement structures and physicians skilled in leadership and quality improvement. Moreover, efforts to improve physician experience has enabled important improvements in the remainder of the *Triple Aim*.

In determining the overall strengths of the evidence for improved physician experience, 4 factors were considered:

- **Breadth of the intervention:** SSC provides a wide range of mechanisms and opportunities for physicians to actively participate in the health care system including support structures, training, participation in quality improvement projects, networking and relationship building.
- **Reach:** Collectively, strategies have a broad reach, reaching a large number of physicians across health authorities and across specialties. One gap, that is currently being addressed, is the engagement and participation of community-based specialists in these initiatives and strategies.
- **Depth:** There is some evidence of deep provider experience impacts especially in the shape of physician interviews and project stories. Overall, data suggests that additional efforts are needed to further strengthen and improve deep engagement between physician and health authorities with respect to meaningful opportunities to collaborate.
- **Durability:** Several strategies are likely to produce results that last including the increase in MSA capacity and the increases in physician capabilities around QI and leadership. For some, participation in quality improvement projects sparked an ongoing interest (perhaps even a passion): "*I'm jazzed! I want to do more.*" (physician speaking of PQI). The attention paid to building strong relationships is also likely to pay dividends moving forward. Despite these strengths, the nature of engagement is such that it must be continually fostered. As such, there is an ongoing need to support these strategies to continue to support physician experience.

The body of evidence supporting SSC's impacts on Provider Experience is extensive. The following sections provide a summary of the key evidence that demonstrates SSC's strong impacts on Provider Experience.

Improved structures and supports that strengthen facility engagement

The Facility Engagement Initiative, launched in 2016, supports physicians who work in acute care facilities across BC to establish a meaningful voice in decisions that impact them and their patients. Through this initiative, a number of robust structures and supports have been provided to build momentum and increase engagement locally. The initiative has had a wide reach, supporting dozens of Medical Staff Associations and reaching thousands of facility-based physicians. It is worth noting here that no counterparts for community-based non-privileged specialists exist, though SSC has recently worked to fill the gap by engaging with this group and adapting some of its initiatives to increase their support to community physicians[22].

22 More information can be found here: https://sscbc.ca/programs-and-initiatives/engage-physicians-health-partners/supporting-community-based-specialists

Key evidence includes:

- **73 MSAs (+ 2 in startup), representing 7,140 medical staff,** are supported through FEI[23]
  - 98% of MSA's indicated that there was improved engagement among MSA members over the last year and 88% reported improved engagement between physicians and health authority.[24]
  - 72% of MSA members agreed that the MSA represented the priorities and collective interests of members
  - 81% of MSA executives and working group members agreed that the Engagement Partner played an important role in supporting progress toward MSA and health authority engagement
  - 77% of physicians agreed that their participation in MSA activities helped them address an issue of importance to them or their colleagues
- **18 Engagement partners** work directly with MSAs and facility-based physicians to support effective governance, engagement processes and strategies
  - 81% of MSA executive and working group members agreed or strongly agreed that Engagement Partners played an important role in supporting progress on engagement[25]
- **Over 100 templates and tools** were developed to help MSAs establish their governance and decision-making structures, communicate with their members, manage their funds and track their progress towards improved physician engagement.
- **Regional tools and supports** including a **regional engagement fund**, a recent addition, to support cross-MSA and health authority engagement on regional issues and initiatives. In addition, a regional knowledge sharing **newsletter**[26], regional **stories**[27] and several regional conferences have facilitated the sharing of knowledge and provided opportunities to improve collaboration and communication at the regional level.

> *"Prior to the FEI, every MSA was different and historically our MSA had some structure and membership. But the formation of the FEI gave it further structure and gave us a route to effective communications with local leadership. It gave meaning and purpose to our MSA." – Physician*[28]

23 September 2021 data; from The Facility Engagement Management System (FEMS).

24 2020 data; FEI's Site Review & Reporting Process data (SRRP)

25 Ference & Company, *Facility Engagement Initiative Interim Evaluation Report*, 2021. More information can be found here: https://facilityengagement.ca/sites/default/files/%28FINAL%29%20FEI%20Interim%20Evaluation%20Report%20-%20Feb%2012%202021.pdf

26 FEI's Knowledge Sharing newsletter can be found here: http://createsend.com/t/d-98804007B8584C8B2540EF23F30FEDED

27 FEI's regional stories can be found here: https://live-facility-engagement.pantheonsite.io/regional-sharing

28 Ference & Company, *Facility Engagement Initiative Interim Evaluation Report*, 2021.

Improved structures and support that enable physicians to implement quality improvement

SSC has implemented several important supports to enable the implementation of physician-led quality improvement. These include supports to participants of the PQI in implementing their Action Learning Projects, supports to teams enhancing access through pooled referrals and supports to teams improving patient experience and patient health through surgical optimization. Evidence suggests that these supports are powerful enablers of quality improvement participation, without which much of the quality improvement participation documented later in this report would be at best frustrating, at worse impossible. One physician shared the importance of sessional fees to building and keeping momentum for quality improvement work: "*This group had been recreated 3 or 4 times over the last few years. There was no momentum. We would have a meeting and then never meet again. FE funding allowed us to meet, build momentum and achieve our objectives…. The reality is that physicians are busy people. If they are attending a meeting or a working group as a volunteer, you should expect that that is a one-shot deal. It's not feasible to ask physicians to continuously and extensively volunteer their time. FE funding is the solution to that."* Moreover, recent evaluation reports have emphasized the importance of continuing to strengthen structures and supports that enable physicians to implement quality improvement.[29]

Key evidence includes:

- **Millions of dollars in one-time funds to support** 50 physician-led projects through an open call for time-limited, specialist-led quality improvement projects (i.e., Quality and Innovation Fund)
- **10 physician quality improvement advisors and 48 SSC-funded staff**, hired within the health authorities, support physicians in the implementation of their Action Learning Projects.
- **Sessional fees** compensate for some physicians' time while implementing quality improvement projects (e.g., FEI; Quality and Innovation) and Action Learning Projects (e.g., PQI).
  - 80% of PQI participants agreed that they were provided with the necessary infrastructure and staff resources to successfully undertake their QI projects[30]
- **Dozens of comprehensive tools, best-practice resources, webinars, networking events and templates, along with key SSC staff,** support providers in implementing pooled referral models and surgical optimization.

> *"Up until that point, I felt like I was beating my head against the wall and being quite frustrated and not being able to affect a lot of change and not getting paid for the efforts that I was making". – Physician (speaking of their participation in PQI)*

29 The Physician Leadership Program (PLP) evaluation can be found here: https://sscbc.ca/sites/default/files/PLP%20Evaluation%20Final%20Report_FINAL%20May%202019%20%282%29.pdf

30 Quatalyst, *Physician Quality Improvement Outcome Evaluation*, 2021

Physicians have developed important leadership and quality improvement skills

SSC develops skills that are important for active participation in the healthcare system including quality improvement skills and leadership skills through 2 of its core initiatives: PLP and PQI. Data suggests that both are having important impacts. A recent evaluation concluded that PLP had "*a significant impact on participants' effectiveness as leaders across a range of dimensions*". Similar, a recent evaluation of the impact evaluation of the PQI initiative found that PQI contributes to building a quality improvement culture[31].

Key evidence includes:

- **530 PLP physician graduates**, including 362 specialists
  - 80% of physician participants agreed that PLP had a significant **impact on their interest in formal leadership roles**[32]
  - 90% of physician participants agreed that PLP significantly **increased their effectiveness as physician leaders**
- **614 physician graduates** of PQI level 1 training
- **889 physician graduates** of PQI level 2 training
- **455 physicians**, across 28 cohorts, participating in PQI level 3 training.
  - 89% of physicians indicated that the program was a worthwhile use of their time[33]
  - 51% reported an increase in confidence and 52% reported an increase in competence in leading QI projects and activities
- **1,559 training scholarships of up to $10,000 awarded,** supporting 994 physicians (including 643 specialists) in ad-hoc, self-identified leadership and quality improvement training

There is an ongoing need for training, even among those who have graduated. Just over half of PLP participants (58%) indicated sufficient support for further leadership development once they had completed their PLP program.[34]

> *"I can't say enough good things. It was huge, huge for me. And I have recommended it to so many people since." – Physician (speaking of PQI)*

> *"I initially went in to improve my skills. But it really sparked my interest in leadership. I realized 'I really like this'." – Physician (speaking of PLP)*

31 Ibid

32 The Physician Leadership Program (PLP) evaluation can be found here: https://sscbc.ca/sites/default/files/PLP%20Evaluation%20Final%20Report_FINAL%20May%202019%20%282%29.pdf

33 Quatalyst, *Physician Quality Improvement Outcome Evaluation*, 2021

34 The Physician Leadership Program (PLP) evaluation can be found here: https://sscbc.ca/sites/default/files/PLP%20Evaluation%20Final%20Report_FINAL%20May%202019%20%282%29.pdf

Physicians have implemented hundreds of quality improvement projects

Quality improvement projects are an important way physicians implement system changes that are important to them and their patients. As shared by one physician, "*the way that most physicians are funded is they're only getting paid if they've got a patient in front of them, really, or they're working directly for one particular patient. So there is not funding for the time to really focus on program development or population changes or system level changes that are going to directly benefit the patient. PQI allows physicians to do that.*"

Many interviewees admitted frustrations in being able to implement important change without the opportunity to be directly funded to implement such a project. As one physician put it, *"Up until that point, I felt like I was beating my head against the wall and being quite frustrated and not being able to affect a lot of change and not getting paid for the efforts that I was making".*

There is tension between the implementation of action learning projects and the alignment of these projects to health authority objectives. As highlighted in both the 2021 PQI evaluation and the 2019 PLP evaluations, alignment to health authority priorities is an ongoing point of interest for the health authority. Interviewees suggested that this tension stems from concerns around health authority resources and the feasibility of ongoing sustainability for successful project. However, the choice of which quality improvement project to implement can also be seen as an opportunity for a physician to exercise their voice. While the precise way in which projects are selected differs across initiatives and health authorities, physicians largely implement projects that are important to them and their patients. In fact, this was one of the driving factors for participating in PQI for one of the physicians interviewed for this evaluation: "*I really wanted to improve the way we did things in my unit so I jumped at the chance to participate in PQI. I had come from a different hospital which had been more efficient. I was so frustrated and really demoralized. Nobody would listen. I wanted to implement an evidence-based protocol that would be both more efficient and provide better patient care. I just needed a chance to prove that my idea would work. PQI was finally the way I could do that. And I did it!*"

Key evidence includes:

- **2,699 engagement and quality improvement projects** implemented by MSAs[35]
- **530 Action Learning Projects** implemented through PLP
- **304 quality improvement Action Learning Projects** implemented through PQI
- **50 quality improvement** projects funded through the Quality & Innovation fund
- **24 pooled referral projects** implemented through the Enhancing Access Initiative
- **13 surgical patient optimization projects** implemented through SPOC

While these projects contribute to improved provider experience, as we detail in a subsequent section, collectively, these projects also show an impact on the other three aims of the *Triple Aim*: patient experience, population health and per capita cost.

35 September 2021 data; FEI's Site Engagement and Activity Tracker (SEAT)

Physicians have contributed their voices to decisions that impact their work

One important component of physician engagement, and therefore physician experience, is having a voice in decisions that impact your work. SSC provides physicians with the opportunity to have their voices heard through many of its initiatives. While most of these opportunities are physician led, Health System Redesign is a health authority led opportunity to engage physicians in providing meaningful input in health authority redesign projects. While data supports that engagement with health authorities is improving over time, data also suggest that there is much work that remains to be done in the area.

Despite the strong evidence of opportunities to contribute voice, there is a strong ongoing need to engage physician in decisions that impact their work and their patients. For example, only 42% of physicians (n=301) surveyed felt that that their MSAs were sufficiently consulted by facility leaders about facility initiatives and processes that directly impact their work environments or patient care[36]. In addition, there is an opportunity to increasingly engage community-based specialist physicians, a group that is the focus on new efforts to engage on the part of SSC.

Key evidence includes:

- **8 SSC fees** were developed and improved through consultation with physicians
- **43 SSC funded Labour Market Adjustment fees** developed and created by 9 Specialist Sections
- **2,537 specialists and 2,364 general practitioners engaged** in 478 health authority system redesign projects
- **329 FE projects and 22 PQI learning action projects** specifically targeting "Engagement & Collaboration" as areas of impact[37]
- **73 MSAs (+ 2 in startup), representing 7,140 medical staff,** are supported through FEI
  - 98% of MSA's indicated that there was improved engagement among MSA members over the last year and 88% reported improved engagement between physicians and health authority.[38]
  - 72% of MSA members agreed that the MSA represented the priorities and collective interests of members
  - 81% of MSA executives and working group members agreed that the Engagement Partner played an important role in supporting progress toward MSA and health authority engagement
  - 77% of physicians agreed that their participation in MSA activities helped them address an issue of importance to them or their colleagues

36 Ference & Company, Interim Evaluation Report, 2021. More information can be found here: https://facilityengagement.ca/sites/default/files/%28FINAL%29%20FEI%20Interim%20Evaluation%20Report%20-%20Feb%2012%202021.pdf

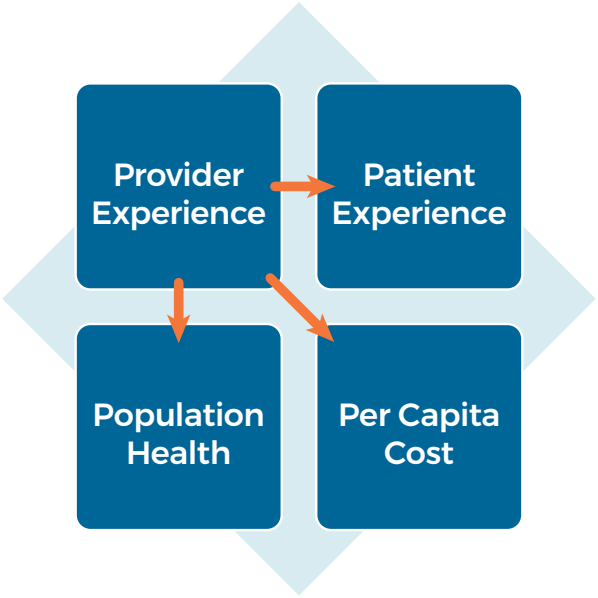
37 Areas of impacts were determined by examining each project's entry on the Exchange: https://sscbc.ca/projects-directory

38 FEI's Site Review & Reporting Process data (SRRP; 2020)

- 15% of PQI physicians reported an increase in "*meaningful input into changes affecting my practice environment*" after participation in PQI[39]
- **Over 200 healthcare providers, leaders and patient representatives** participated in the SSC specialist symposium, co-hosted with the Specialists of BC in 2018, which gathered feedback on the priorities of the specialist population[40]
  - 95% of participants said the Symposium created opportunities for physicians to provide feedback on emerging issues impacting specialists care in BC
  - 92% of participants said the Symposium create opportunity for collaborative discussion across disciplines and system partners
- 10+ SSC funded, **third party evaluations** have gathered physician input on SSC initiatives and strategies

Physician experience is an important enabler of the *Triple Aim* and of culture of quality

It is worth highlighting that SSC's achievements with respect to provider experience might in large part be responsible for the remainder of the successes you will read in the next 2 sections. Physician interviews strongly suggests that provider experience is an enabler of the remainder of the triple aim. As you will read, it is physician's active participation in the health system, through training and the implementation of quality improvement projects and engagement structures and processes with health authorities, that the remainder of *Triple Aim* improvements result. Said another way, supporting strong physician experience builds a culture of quality and collaboration.



39 Quatalyst, *Physician Quality Improvement Outcome Evaluation*, 2021

40 More information on the Symposium can be found here: https://sscbc.ca/news/2019/03/13/specialist-symposium-shaping-future-specialist-care-bc

SSC has had important impacts on Patient Experience and Population Health

There is moderately strong evidence of improved *Patient Experience and Patient Health Outcomes*

Strength of the evidence: ●●●◐○

There is moderately strong evidence of improved Patient Experience and Patient Health Outcomes. Several initiatives and projects across SSC have worked to improve patient pathways of care resulting in improved patient experience and patient health outcomes. Notable improvements were achieved in improving patient access and patient centeredness including through fees that enable rapid access to specialist advice, pooled referrals, telehealth and the implementation of other best practices. Several projects also focused on improving patients' surgical journeys including prehabilitation before surgery and improved patient pathways after surgery. Collectively, the evidence is moderately strong. While there is much evidence of an abundance of physician led projects aimed at patient experience and patient health outcomes, robust documentation on processes and outcomes related to these projects is only occasionally available.

Patient experience is a complex construct that includes the patient's entire journey through the healthcare system. A key focus for SSC, is improving patient experience by increasing access to specialist care.[41] Early in its strategic journey, SSC created a number of fees, each utilized thousands of times by hundreds of physicians, which supported patient access to specialist care.

SSC added to its strategies in 2012, by funding a wide range of Quality and Innovation projects supporting physicians to lead quality improvement projects focused on the Triple Aim. In total, 50 projects were funded. While the robustness of available data varied across projects, a number showed strong positive impacts on patient experience and patient health.[42]

SSC's approach to improving patient experience and patient health has more recently been focused on initiatives that provide strong centralized supports, in particular the Enhanced Access Initiative focused on supporting physicians to implement pooled referrals and SPOC focused on supporting multidisciplinary teams to implement prehabilitation processes and components.

Learning action projects implemented by physicians participating in PQI and PLP also contribute to improved patient experience and patient health outcomes. Unfortunately, available documentation on the implementation and outcomes of these projects make it difficult to ascertain the extent of their impacts on patient experience and patient health. Nonetheless, they do provide evidence of focused activities in this area.

In determining the overall strengths of the evidence for improved patient experience and patient health outcomes, 4 factors were considered:

41 The *Physician Master Agreement* is available here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/2019_physician_master_agreement.pdf

42 Information on many of these projects can be found here: https://sscbc.ca/system-improvement/quality-and-innovation-initiative

- **Breadth of the intervention:** Collectively projects were extremely varied and covered a wide range of mechanisms and approaches. While projects were distributed across health authorities and covered a number of speciality areas, it is not known to what extent projects were facility based or community based. A review of the projects suggests that while Quality & Innovation fund projects were more evenly distributed between the two, more recent projects (PQI and FE) are localized more heavily within facilities – though more systematic data would be needed to verify these results.
- **Reach:** While no easily quantifiable systematic data was available on the patient populations targeted by these initiatives, the available documents suggest a wide range of patients across the lifespan benefitted from the care transformations, including maternity, child and youth, adults and geriatric patients. Moreover, projects appeared to span both acute and chronic care. Despite this wide reach, many projects were local implementations and/or pilot implementations limiting the overall reach of their impacts. That is, projects were implemented in single geographical location (or department), sometimes for a time-limited fashion. These project constraints limit the overall reach of the impacts.
- **Durability:** The sustainability of many projects is unknown. For the majority of projects reviewed by this evaluation, it was not immediately known whether projects were sustained or sustainable over time. In some instances, sustainability seemed likely, for example where new patient pathways were created and embedded within workflows. In other instances, where sustainability depended on the availability of funds (e.g., for training, for ongoing technological costs), sustainability seemed more tenuous. Given that project reports were generally created soon after project completion, data on long term sustainability was generally not available in existing documentation.
- **Overall availability of data:** There is ample evidence of quality improvement work aiming to improve patient experience and health care outcomes. However, the overall availability of robust outcome data is more limited. Survey and interview data suggests that quality improvement projects lead to important outcomes. For example, the PLP evaluation found that a majority of participants and sponsors (62% and 63% respectively) indicated that projects led to improved patient outcomes. Impressively physicians and sponsors reported that over 40% of those projects led to changes that went beyond their site/community including at the health authority level or regional level (32%) and provincial level (11%).[43] Similarly, the 2021 FEI evaluation found that key informants perceived FEI to be effective in contributing to improved quality of patient care citing several project examples[44]. Nonetheless, robust outcome data is available only in a portion of projects and that, usually only over a relatively short time frame. And even where outcome data is presented, data limitations and confounding factors are not generally discussed, preventing a full understanding of the depth of project impacts. There are notable exceptions to the

43 The 2019 PLP evaluation report can be found here: https://sscbc.ca/sites/default/files/PLP%20Evaluation%20Final%20Report_FINAL%20May%202019%20%282%29.pdf

44 Ference & Company, Facility Engagement Initiative Interim Evaluation Report, 2021. More information can be found here: https://facilityengagement.ca/sites/default/files/%28FINAL%29%20FEI%20Interim%20Evaluation%20Report%20-%20Feb%2012%202021.pdf

availability of data, including SPOC, which was a centrally supported initiative rather than project.

Despite the limitations in the available data, moderately strong evidence suggests important improvements to patient experience and patient health outcomes. Key evidence is presented below.

Key evidence includes:

Improving Access and Reducing Wait Times

- **5 SSC Fees**[45] supporting improved access were created and implemented:
  - **Urgent Specialist Advice** Fee (G10001) **utilized over 1 million times** (1,017,306)
    - urgent real-time advice another healthcare provider to replace the need for the specialist to see the patient in person.
  - Specialist Advice for Patient Management (G10002) **utilized 190,562 times**
    - real-time advice to another healthcare provider to replace the need for a patient in-person visit
  - Specialist Patient Management Fee (G10003) **utilized over 1 million times** (1,181,487)
    - telephone and video communication, replacing the need for in-person visit
  - Specialist **Email Advice** for Patient Management (G10005/6) **utilized 257,109 times**
    - email advice to replace the need to see the patient in person
  - **Group Medical Visit** Fee (G787**)[46] **utilized 245,476 times**
    - allows specialist to see several patients during a single visit
- **352 quality improvement projects** focussed on improving patient access were implemented across all health authorities[47]
  - 266 MSA projects
  - 58 learning action projects implemented through PQI
  - 28 Quality & Innovation projects

45 Utilization data is from the fee's inception to the end of the 2020 fiscal year (March, 2021).

46 The Group Medical Visit (GMV) fee is a group of fees whereby the fee code changes based on the size of the group. For the purposes of utilization, the entire group is considered as a single fee.

47 SSC projects listed in the Exchange and indicating an impact on "Access" were included in these analyses.

- **Wide range of quality improvement strategies were implemented** to increase patient access including:
  - **Pooled-referral** projects targeting several different specialty areas
    - Several Q&I projects showed positive outcomes (e.g., ReBalance) in addition to laying the foundation for a repeatable pooled-referrals implementation process
    - Reduction of an average of 75 days in Wait 1 time for all Enhanced Access Initiative projects[48]
  - Other strategies aimed at increasing patient access included**, tele-health**, the implementation of **best practices** and improved **care coordination**

Improving Patient Centeredness and health outcomes

- **Patient representation**
  - Patient partners are included at PQI decision-making tables
- **SSC Fees** supporting strong patient journeys through the healthcare system
  - Complex Care **Discharge Planning** Fee (G78717) utilized **122,962 times**
    - ensures complex patients have a detailed care plan following discharge from hospital to ensure appropriate care coordination and follow-up
    - increased satisfaction among patient families with receiving written discharge care plans and improved communication between specialists and primary care providers[49]
  - The **Multidisciplinary Conferencing** for Complex Patients Fee (G10004) **utilized 205,689**
    - Supports the coordination of care between multidisciplinary providers for patients with serious and complex problems
  - The Specialist **Advanced Care Planning** Fee (G78720) **utilized 91,905 times**
    - incentivizes specialists to discuss and document the patient's wishes for future health care, in the event they become incapable of making such decisions in the future

48 Hutchinson & McIvor, *Enhancing Access Initiative Evaluation Results*, 2021. More information can be found here: https://sscbc.ca/news/2021/08/31/enhancing-access-initiative-decreases-patient-wait-times-average-75-days

49 MNP, *Specialist Services Committee Outcome Evaluation*, 2014.

- **490 quality improvement projects** focused on improving patient centeredness and patient care journeys[50]
  - 418 MSA projects
  - 36 learning action projects implemented through PQI
  - 23 Quality & Innovation projects
  - 13 SPOC
    - 7,348 patients screened and 4,407 patients received pre-surgical optimization through SPOC
    - 92% of patients reported that their surgical experience was improved as a result of the information and care provided by their SPOC care team[51]
    - 78% of patients reported that their overall health has improved as a result of the information and care provided by their SPOC care team
    - Over 80% of patients showed measurable improvements in several clinical areas included substance use**,** VTE, cardiac, glycemic control, physical activity, anxiety, smoking and frailty.

SSC has had a positive impact on Per-Capita Cost of Healthcare

There is moderate evidence of reduced *healthcare costs*

Strength of the evidence: ●●●○○

The availability of evidence is more difficult with this last triple aim. Calculating healthcare related costs savings is excessively difficult and in a complex environment, there is a real danger in examining costs from a simplistic lens. The measurement of cost savings and cost avoidance is likely only appropriate in a very small set of SSC projects and initiatives. As such, showing strong impacts in reducing the per capita cost of healthcare is likely not currently feasible. Nonetheless, hundreds of SSC projects, implementing a wide range of strategies and mechanisms, have worked to improve the efficiency and appropriateness of health services. There are a few very strong examples of cost savings, however, SSC's work collectively, provides moderate evidence of positive impacts on healthcare costs.

Calculating healthcare related costs is excessively complex. In a complex environment, there is a real danger in examining costs from a simplistic lens. For example, the vast majority of SSC quality improvement projects in this section did not include balancing measures, or if they did, they were not presented in available documentation. A balancing measure helps determine

50 The Exchange projects listing "integration" and "acceptability" as impacts are included in these analyses.

51 The SPOC evaluation can be found here: https://sscbc.ca/sites/default/files/SPOC%20Evaluation%20Report%20Final%20Sept%202021.pdf

whether changes designed to improve one part of the system is causing new problems in another part of the system. For example, in some projects, an inappropriate reduction in length of stay may lead to an additional acute care admission. Unless these types of additional measures are included, to balance the measurement, a project may report cost savings by missing the additional costs occurring elsewhere in the system.

An additional hurdle is the size of many of these quality improvement projects. Detecting statistically and clinically significant changes in quantitative data requires a sufficiently large sample size. Other methodological considerations include the representativeness of the sample and the presence of confounding variables.

Even with appropriate methods in place, complex system cost savings and cost avoidance are extremely difficult to measure without robust measurement infrastructures in place. The situation is made even more difficult when an intervention in one system is intended to lead to cost savings in another. For example, an acute mental health intervention may add costs to the healthcare system but reduce costs in the criminal justice system.

Moreover, many quality improvement initiatives don't aim to save costs immediately but rather aim to save costs later, a term referred to as cost avoidance. In this respect, indicators of reduced per capita costs are likely to be lagging indicators – indicators that appear later, sometimes much later. Given that many of the SSC's quality improvement projects occur over a relatively short time frame, showing cost avoidance within the project window will often not be possible.

Given the above, the measurement of cost savings and cost avoidance is likely only appropriate in a very small set of SSC projects and initiatives. As such, showing strong impacts in reducing the per capita cost of healthcare is likely not currently feasible.

Nonetheless, hundreds of SSC projects, implementing a wide range of strategies and mechanisms, have worked to improve the efficiency and appropriateness of health services. While there are very strong examples of cost savings, SSC's work collectively, provides moderate evidence of positive impacts on healthcare costs.

Key evidence includes[52]:

- **441 quality improvement projects focussed on improving efficiency across all health authorities**
  - 316 MSA projects
  - 89 learning action projects implemented through PQI
  - 23 Quality & Innovation projects
  - 13 SPOC surgical optimizing projects

52 The Exchange is an online searchable database of quality improvement projects supported by SSC. Launched in 2018, it was created to facilitate the sharing of quality improvement ideas and project information. The database currently lists 1,592 quality improvement projects across 5 SSC initiatives. While not all SSC projects since 2010 are listed, it does provide an understanding of the volume of projects undertaken by physicians. Note that while SCC projects are also listed in the database, they are excluded from these analyses. See here for The Exchange database: https://sscbc.ca/projects-directory

- **542 quality improvement projects focussed on improving appropriateness across all health authorities**
  - 363 MSA projects
  - 133 learning action projects implemented through PQI
  - 33 Quality & Innovation projects
  - 13 SPOC surgical optimizing projects
- **Wide range of cost-savings mechanisms implemented** to reduce healthcare system costs including:
  - **Telehealth** (e.g., telemental health)
  - **Prehabilitation** to reduce surgical risk factors (e.g., smoking cessation)
  - Enhanced recovery after surgery (e.g., improved patient pathway)
  - Reduction in unnecessary procedures (e.g., urine cultures)
  - **LMA fees** incentivizing procedures that result in reduced lengths of stays (e.g., laparoscopic hysterectomy fee)
  - **SSC fees** that improve clinical care coordination and continuity of care, reducing unnecessary readmissions (e.g., complex care discharge planning fee)
- **Patient costs reduced through tele-health**
  - Reduction in travel time and fuel costs associated with healthcare travel
- **Robust economic analyses** and/or other evaluation data supports significant cost reductions in an important **subset of projects** across SSC Initiatives. For example:
  - BC Hip Fracture Redesign (Q&I)[53]
  - Surgical Patient Optimization (SPOC)[54]
  - Alcohol Use Disorder Treatment (PQI)[55]
  - Endoscopy Cost Savings Project (FE)[56]

"Cost is one of these lagging indicators. It often doesn't make sense to measure it in the short term" – Physician

" I am sure, absolutely sure, that our project saves the system money. But that's long term. We don't save money right now. We save money over the long run. Patients are not readmitted, their health is more stable, they are having fewer follow-up visits." – Physician

53 More information can be found here: https://sscbc.ca/projects/bc-redesign-hip-fracture-care

54 More information can be found here: https://sscbc.ca/programs-and-initiatives/transform-care-delivery/surgical-patient-optimization-collaborative-spoc-0

55 More information can be found here: https://sscbc.ca/news/2021/01/28/helping-change-paradigm-treatment-alcohol-use-disorder-bc

56 More information can be found at page 33 here: https://facilityengagement.ca/sites/default/files/FacilityEngagementActionBookletDigitalVersionMay252020.pdf?search=engaging%20physicians%20to%20improve%20bc%20health%20care

Future opportunities

There is ample evidence to suggest that SSC has had an impact on the *Triple Aim*. Collectively SSC's body of work has had a wide reach and impacted a large number of patients and physicians. While evidence is stronger for some components of the *Triple Aim* than others, SSC has made positive impacts across all of the *Triple Aim*. Despite these large impacts, the evaluation supports an ongoing need for SSC's focus on improving physician engagement, developing physician capabilities and transforming care delivery.

The evaluation reviewed a considerable number of documents, all providing a strong sense of the abundance of activities aimed squarely at the *Triple Aim*. To better understand the impacts of these activities, including the sustainability of those impacts, more robust evaluations and documentation is essential. This is especially true at the project level. Without this robustness, it is not possible to understand the full extant of SSC's impacts. Indeed, most estimates of its impacts will likely be an under-estimation.

Over the last 10 years, SSC has had substantial impacts on the *Triple Aim*. It's current emphasis on strong, collaborative, system change promises to further this momentum and to continue to improve the *Triple Aim* for the people of British Columbia.

> *"I'm grateful that these resources exist. I can honestly say that I am a changemaker now." – Physician*
>
> *"In the past, physicians felt powerless to make changes. But now that we have a formal structure in place, we can actually bring ideas forward and see changes that are made from those ideas." - Physician* [57]
>
> *"The prescription for physicians suffering with disillusionment, frustration and burnout is to participate in Quality Improvement. PQI is an antidote to cynicism" – Physician*[58]

57 Dr. David Stoll, Penticton Regional Hospital, quoted in the 2020 Facility Engagement Booklet found here: https://facilityengagement.ca/sites/default/files/FacilityEngagementActionBookletDigitalVersionMay252020.pdf?search=engaging%20physicians%20to%20improve%20bc%20health%20care

58 Dr. John Galbraith quoted in the 2016/2017 SSC Annual Report found here: https://sscbc.ca/sites/default/files/Annual%20Report%20Layout%20SSC%202017%20Final.pdf