



SPECIALIST SERVICES
COMMITTEE

SPECIALIST SERVICES COMMITTEE

► Report for the Period 2010/11 and 2011/12

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BACKGROUND

The Specialist Services Committee (SSC) was created in 2006 to facilitate collaboration between the Government of British Columbia and the BC Medical Association (BCMA) on the delivery of services by specialist physicians to British Columbians and to support the improvement of the specialist care system.

The Physician Master Agreement and the Specialists Subsidiary Agreement between the Government of BC, the BCMA, and the Medical Services Commission (MSC), discuss the support for access to and improvement of specialist services:

The Government and the BCMA agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients' medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options and health human resource options.

MANDATE

The SSC continues its efforts to enhance and expand programs that support the delivery of high quality specialty services to British Columbians.

In 2009, the introduction of the Memorandum of Agreement increased funding for the SSC to continue its work to expedite patient access to specialist consultations. Focuses of the SSC include:

- 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 specialist physicians in BC.

Organizational Structure

The SSC is a joint committee of the Ministry of Health and the BCMA. The BCMA has four appointed members: Dr Ken Seethram (co-chair), Dr Ian Courtice, Dr Gordon Hoag, and Dr Sean Virani. The Ministry also has four appointed members and has delegated two of its member positions to health authority representatives to ensure regional participation: Ms Nichola Manning (co-chair), Mr Jeremy Higgs, Dr Steve Gray, and Dr Richard Crow. (Appendix A)

REPORT ON ACTIVITIES

Overview

With the patient as its focal point, the SSC continues its efforts to create an effective and efficient specialist care system.

In 2010, the SSC implemented telehealth billing capacity, and had baseline and mid-term evaluations conducted to ensure new fees and programs are properly evaluated for system improvements and effectiveness.

The SSC made great progress in 2011 moving initiatives forward and working through the issues associated with implementing new fees and programs. These efforts, combined with physician interest in the committee's initiatives, have presented great opportunity to enhance the effectiveness of specialist care in the province with the primary objective of improved patient care.

Some SSC initiatives include an external review of the medical consultant services projects, conducting the labour market adjustment process with the assistance of an advisory group, and holding a special planning meeting with committee members and stakeholders to focus direction and prioritize ongoing efforts. As well, the committee co-chairs attended Society of Specialist Physicians and Surgeons council meetings to provide updates and seek feedback on the SSC's initiatives.

The committee will continue to move forward innovative and relevant initiatives to benefit patients, physicians, and the health care system. Momentum will continue through the increased communication and consultation efforts with specialist physicians and among stakeholder groups.

Surgical Specialist Subcommittee

The SSC continued to connect through other committees of similar scope of focus on waitlist strategies and access to care.

Principles and Priorities

When developing new initiatives, the committee continues to keep the Institute of Healthcare Improvement's Triple Aim principles (modified) and the SSC's own guiding principles at the forefront.

Triple Aim principles (modified) include:

- Improve the health of the population.
- Enhance the patient (and provider) experience of care (including quality, access, and reliability).
- Reduce, or at least control, the per capita cost of care.

Building upon the objectives of the Triple Aim, the SSC's guiding principles include:

- Addresses a care gap (improves the health of a defined population).
- Improves/benefits patient experience.
- Improves/benefits provider experience.
- Demonstrates a positive cost benefit.
- Improves collaborative practice.
- Improves/supports patient engagement.
- Has an achievable, measurable outcome.
- Encourages efficient capacity.
- Encourages appropriate access to care.
- Improves knowledge, skills, and judgment of individual physicians that will positively affect patient management and outcomes.

The SSC previously selected four non-surgical priority areas with a goal of expediting access and assessment for specialist care. The following priorities continue to influence SSC initiatives and were selected based on identified need, provincial impact, and opportunity for viable recommendations:

- Telehealth expansion
- Pain management
- Internal medicine capacity
- Medical quality assurance

Planning

In October 2010, the SSC held a planning discussion with committee members and stakeholders. Participants were presented with an overview of the Ministry's key result areas and discussions revolved around the changes in the specialist environment. The group looked at ideas for moving forward and developed priorities in a brainstorming exercise.

Allocation

With the 2009 Memorandum of Agreement, the SSC received increased funding starting April 1, 2010 of \$20 million per year and on April 1, 2011, received an additional \$25 million per year for a total of \$45 million per year.

The increased compensation was intended to support the SSC's work in enhancing and expanding the programs that support the delivery of high quality specialty services to British Columbians.

Fees

From concepts discussed at the 2009 Specialist Think Tank and the 2010 SSC Planning Day, as well as extensive consultation with Specialist Sections, the SSC selected and implemented the following initiatives over 2010 and 2011:

- **Perioperative Billing Limits:** The SSC change to the MSC Payment Schedule Preamble is intended to update billing rules and help improve patient care. The previous perioperative billing rules paid for patient visits up to two weeks preoperatively and after six weeks postoperatively. As of April 1, 2010, specialists are paid for all preoperative visits, all in office postoperative visits, and all in-hospital visits 14 days postoperatively.
- **Physician to Physician Telephone Communication:** A new communication fee structure was introduced to address appropriate referrals, help the primary care physician manage patient care, prevent inappropriate or unnecessary referrals, and prevent emergency room visits and acute care admissions and readmissions. Fees became effective April 1, 2010, for specialist physicians to respond to requests for telephone advice from general practitioners or other specialists. The fee structure is based on the urgency of the advice requested. Urgent requests are responded to within two hours and non-urgent requests within a one-week period.
- **Specialist to Patient Telephone Communication:** This fee was developed to replace the need for an office visit by conducting a scheduled telephone call between the specialist and their patient when appropriate. The fee was implemented on April 1, 2010, and intends to create capacity in specialists' practices and at the same time improve patient access and provide more efficient patient care.
- **Discharge Planning Fee:** A new fee will be developed and implemented in 2012 with the intention of providing an incentive for coordinated care planning upon hospital discharge. Specialist physician involvement in the discharge processes will better coordinate multidisciplinary care and provide valuable discharge information to patients and their general practitioner with the aim to reduce readmission and improve patient care.
- **Advance Care Planning Fee:** An advance care plan allows patients to plan their future health care wishes in case they are incapable of making these decisions on their own at a later date. A fee premium to encourage advance care planning discussions will be developed in 2012 to support the government's My Voice advance care planning tools. The goal is to see better coordination with primary care providers and opportunities for discussions with patients around advance care planning decisions.

Initiatives

- **Practice Support for Specialist Physicians:** Practice Support Program (PSP) learning modules, originally created for general practitioners will be revised for specialist physician participation. The learning modules available for specialist physicians are advanced access, group medical visits, and office efficiency. Others, including end of life care, are under development.

Specialists and their medical office assistants who participate in PSPs will be compensated for their time commitment by the SSC. Implementing an advanced access model in specialist physician practices is proven to create additional system capacity, improve patient care, and increase physician and patient satisfaction.

- **Funding for Physician Participation in System Redesign Activities:** With an increased focus on system process redesign and Lean type activities to make the health care system as efficient and effective as possible, the SSC recognized physician participation in those activities is essential. The SSC actively promoted the inclusion of physicians in these discussions and activities with health authorities by funding selected physicians' time to participate. By including physicians in these discussions health authorities can capture unique physician perspectives and ultimately achieve better support of the revised processes.
- **Physician Leadership Training Scholarships:** In early 2011, the SSC introduced scholarships for physicians to receive training in leadership activities. Applications require endorsement by a health authority executive prior to committee approval. This allows the physician to indicate their interest in health authority leadership activities and to help start those discussions. Leadership training for physicians is intended to complement the health authority redesign program, allow both parties to get the most out of the physician engagement, and to identify and develop new physician leaders.

Program Evaluation

A baseline evaluation and survey was conducted by an independent consulting group with the rollout of the new initiatives. The baseline information ensured the impact of the initiatives could effectively be measured and evaluated.

As part of the 2011 mid-term external evaluation, consultants interviewed and sought feedback from the SSC and its stakeholders including specialist sections, the Society of Specialist Physicians and Surgeons (SSPS), health authority representatives, and staff of the SSC and the Practice Support Program for specialists. The SSC also contracted with a public opinion polling firm to assist in surveying GPs and specialists across the province on their perceptions of the SSC initiatives as well as physician communication and collaboration.

The key evaluation findings were:

- There is a strong need for the SSC initiatives in BC.
- The SSC initiatives have had positive impacts and have made progress toward achieving their intended objectives since its implementation in April 2010.
- Program uptake varies across the SSC initiatives.
- There is an opportunity to improve the communication and promotion of the SSC initiatives.
- There is an opportunity to tailor the SSC program offerings and content to make them more effective and relevant to specialists.
- The implementation of the new perioperative billing rule changes resulted in expenditures that exceeded the original allocation due to higher than anticipated billing of fees by some specialist sections.

The SSC is pleased that the initiatives overall are perceived as having a positive impact for both physicians and patients, particularly regarding the support for improving communication and collaboration between physicians and improving access and quality of care for patients.

The SSC will ensure that opportunities for improvement are acted upon, including changes to the implementation and promotion of the initiatives. Going forward, the SSC will also be working to engage more with specialists directly as well as through the sections and the SSPS to obtain input and feedback on current and proposed new initiatives to support the work of specialists within the health system.

Medical Consultant Services

The SSC funded 38 projects over three years as specified in the Specialists Subsidiary Agreement. The projects were geared toward providing support for primary care providers in the areas of mental health, addictions, Aboriginal health, geriatric care, chronic pain, and pediatrics.

While several projects were short term, a number of pilots have carried on as successful programs and some have expanded from their original scope.

Pilot projects funded through the third round of medical consultant funding were evaluated in the fall of 2010. Of the 38 projects funded over the three years, 14 were considered successful and moved to ongoing funding through the alternate payments program. Another nine projects continued under the SSC for review in 2011.

In the summer of 2010, the SSC engaged external consultants to conduct a comprehensive review of 22 of the projects from the first two funding rounds.

The evaluation was comprehensive and provided a thoughtful and detailed review of the services provided through the medical consultant funding and greatly assisted the SSC in making decisions to move pilot projects forward into programs or to allow other projects to wrap up.

A number of criteria were used to assess projects, but key were mandatory criteria set out by the SSC such as ensuring patient focused care, supporting primary care providers through specialist services, and enhancing access to specialist services.

Projects

The following successful projects moved to ongoing funding as part of the alternative payments funding to health authorities.

PROJECT	SERVICE
VANCOUVER ISLAND HEALTH AUTHORITY	
Enhanced Skills Training Approach to Collaboration, Urban (Downtown and Community) and Rural (Sooke) Physician Lead: Dr R. Weinerman	Enhanced skills module of collaborative care and consultation liaison. Integrated collaborative care model for Victoria and Sooke. Enhanced skills training offered to GPs who are noted to refer widely and perhaps unnecessarily into the psychiatry secondary care system. To enhance the GP skills, the project will support them to offer quality primary care to mildly and moderately mentally ill and addicted patients before they are referred to the secondary system.
Mental Health and Addiction Services to the Vancouver Island First Nation Communities of Ahousaht and Kingcombe Inlet Physician Lead: Dr R. Kamil	Aimed to create an integrated model of care (focus on mental health and addictions) for First Nation peoples in Ahousaht and Kingcombe Inlet. Services include individual, marital/couple, family, and group therapy; justice system assessments, liaison with community, and collaborating with local GPs.
Ladysmith Community Health Centre – Mental Health and Addictions Physician Lead: Dr M. Cooper	Partnership between Ladysmith Primary Health Care Services and Cowichan Valley Mental Health and Addictions Services to support primary mental health care for patients in Ladysmith. Psychiatric consultation within a shared care model, and support and education for the primary health care team.
Off the Beaten Path: Providing Equitable Medical Genetics Services Throughout VIHA Physician Lead: Dr L. Arbour	Medical genetics outreach to VIHA areas poorly served (Courtenay, Campbell River, etc.) focus on children and families with genetic conditions, including those with disabilities. Intend to conduct genetics clinics in the community or in GP offices including ongoing care plans and supportive literature.
Enhancing Psychiatric Care for Children and Youth Physician Lead: Dr P. Firstbrook	Integrated treatment planning for psychiatric care for children and youth in Saltspring Island, Sooke, and South Island. Direct and indirect consultations, integrated treatment plans, educational plans designed to improve access, continuity of care, increased collaboration, increased compliance with referrals, knowledge transfer, better use of psychiatric resources, and easier access to intensive services.
Pain Management Support to Primary Care Physicians and Patients Physician Lead: Dr N. Svorkdahl	Complex case rounds hosted each week at one of the tertiary pain centres in VIHA (Royal Jubilee and Nanaimo Regional General Hospitals) provides an opportunity for an interdisciplinary review of specific pain cases complicated by a host of pathophysiological, psychological, and functional factors. Primary care physicians are invited to submit summaries for initial evaluation and/or ongoing case management from up to five VIHA specialists at one meeting to enhanced efficiency for GPs and their patients.

PROJECT	SERVICE
INTERIOR HEALTH AUTHORITY	
Collaborative Care Physician Lead: Dr S. Naicker	Leverage role of GPs to increase mental health care for patients through access to psychiatrists and mental health clinicians. Additionally, support GPs via psychiatric review, consultation, or education to reduce acute manifestations of illness. Telepsychiatry from Trail to smaller communities will be introduced.
Collaborative Mental Health and Substance Abuse for Youth Project Lead: Mr J. Marshall	Adds a psychiatrist to a collaborative care initiative involving about 50 GPs at three sites who request direct or indirect services and a number of youth clinicians who care for marginalized youth with mental health and/or substance abuse issues. Direct services for clients in GP offices and at the Boys and Girls Club, indirect services for GPs including telephone consultation, and supervision and support for youth clinicians in the field.
Developmental Disability Consultation Physician Lead: Dr B. Pipher	Improve integration of specialist and primary care for children, youth, and adults with developmental and learning disabilities. Specialist consultation for pediatrics and psychiatry to support primary care providers across Interior Health using networks of assessment and treatment to provide earlier identification, assessment, diagnosis, and recommendations to reduce the long-term impact of secondary disabilities in the population.
Outreach Urban Health Primary Care Centre: Infectious Disease/ HIV Specialist Consultation Project Lead: Mr A. Hughes	Primary care centre (urban outreach) in Kelowna serving the disenfranchised population including patients with HIV and Hep C virus, staffed by rotating GPs and a care team. Increasing numbers of homeless patients with infectious disease issues were proving to be a real challenge for physicians. Project provides specialist physician support to GPs in order to retain GPs at clinic, improved primary care support to increase satisfaction and sense of competence, decrease ED visits and admission rates, and improve health outcomes by improving accessibility, continuity of care, health conditions, follow-ups, and medication treatment.
Regional Medical Addictions Specialist Project Lead: Ms C. Todd	Training and services development including teaching modules and evidence-based tools. Services include brief in-person intervention training to physicians in Interior communities includes follow-up support and consultation as required via phone conferencing and video services, training to physicians, and the dissemination of withdrawal management best practices and evidence-based protocols to support primary care services for withdrawal management, support to physicians regarding the expansion of methadone services at the primary care level, and the integration of multidisciplinary services to provide health care to a population with complex care needs.

PROJECT	SERVICE
NORTHERN HEALTH AUTHORITY	
<p>Specialist Involvement in the Primary Care Treatment of Blood-borne Pathogens Physician Lead: Dr A. Hamour</p>	<p>Develop a model to support rural GP treatment of patients with blood-borne pathogens due to increasing HIV and Hep C infections in the North and particularly among First Nations. GP-specialist shared care model; specialist care or specialist guided GP care that is sensitive to patient's geographic location and socioeconomic status, and specialist regional satellite clinics and videoconference support to GPs.</p>
<p>Vancouver Coastal Health Authority Inflammatory Arthritis Outreach Clinics Physician Lead: Dr A. Klinkhoff</p>	<p>Expansion of an existing program to fund a rheumatologist to provide outreach services to increase patient access to rheumatologists in their own communities (in person or via telehealth), improve patient care via earlier diagnosis, reduce wait-times for consultation, provide knowledge transfer among professions, working shared care model with GPs and multidisciplinary team.</p>
<p>UrbanDoc Psychiatry Shared Care Program Physician Lead: Dr R. Borkenhagen</p>	<p>Provides consultation services by seven psychiatrists for 22 Vancouver GPs to support them in caring for employed patients who require services for mental health conditions (depression, anxiety, and bipolar disorders). Improve patient access, maintain patients in workforce by timely intervention, decrease impacts on acute care system, improve GP and specialist relations through opportunities for collaboration, improve and enhance capacity of GPs to manage patients with mental health and addictions conditions, and improve patient care through innovative and more responsive communication and collaboration with GPs.</p>
<p>Pacific Adult Congenital Heart Clinic (Providence) Physician Lead: Dr M. Kiess</p>	<p>Patients with moderate and complex adult congenital heart disease have chronic illnesses with significant medical, neurocognitive and psychological disorders, learning and physical difficulties, and social and financial issues that must be addressed. The program objective is to significantly increase the multidisciplinary support these patients receive both in the community and in referral to the tertiary setting when required. Funding provides cardiologists trained in the subspecialty of adult congenital heart disease is essential to assist primary care and other physicians in the care of patients, increase number of patient clinic visits, number of days per week the clinics are held, and develop outreach clinics that will improve access to GPs, the patients, and their families.</p>

PROJECT	SERVICE
<p>Family Practice Shared Mental Health Care Services (Richmond) Physician Lead: Dr S. Zipursky (ret.) Project Lead: Ms Y. Jetha</p>	<p>Provide appropriate and timely early intervention mental health services, reduce client risk by increasing access, address service gaps, and improve quality of care (reducing ED visits and admissions). Educate and build capacity through promotion of self-management strategies, engage high-risk patients, build capacity in GP community through integrated care model, use treatment model to support the VCH women’s reproductive care mental health clinic.</p>
<p>HIV Management – Specialty Shared Care Project Lead: Mr D. Portesi</p>	<p>Increase local access for patients living with HIV/AIDs to GP and specialist care, enhance access and adherence to HAART and other treatments, increase support and capacity of GPs in the community, use a multidisciplinary team in a shared care model. Services include specialist care for patients, preceptorship opportunities in HIV clinics, creation of a practise community of GPs caring for patients with HIV, and training opportunities for GPs through consultation, workshops, and development of educational materials.</p>
<p>Collaborative Strategy for Improving Patient Care in Mental Health Involving GPs and Psychiatrists Physician Lead: Dr T. Isomura</p>	<p>Three GP clinics in Fraser Health for patients with depression and anxiety to be referred to psychiatrists for direct care. Indirect consultations with GPs include discussions about referred cases, treatment, and follow-up care. Project establishes collaborative working relationships between GPs and psychiatrists to improve mental health outcomes for patients, reduce waiting times to see a psychiatrist, improve patients’ quality of life, improve patient satisfaction with care, and reduce number of inappropriate/unnecessary hospitalizations. Enhance the ability, skills, and satisfaction of GPs in diagnosis and differential diagnosis, use of interventions such as CBT, and management of patients with chronic mental illness.</p>
<p>Provincial Health Services Authority Social Pediatrics (SPI) and Specialist Physician Outreach Consultations for Kids (SPOCK): A Community, VCH & PHSA Partnership Physician Lead: Dr C. Look</p>	<p>Provide full spectrum (primary to specialized) health services, to children and families who are vulnerable due to their social and material circumstances. SPOCK is the specialist component of a carefully planned and prospectively evaluated research informed practice initiative entitled RICHER (Responsive, Inter-sectoral, Child/Community Health Education and Research), a community outreach program originating out of partnerships with UBC, BC Children’s Hospital, VCHA, and Vancouver’s inner-city community. The initiative is resourced by specialists and subspecialists in pediatrics, psychiatry, and adolescent medicine, committed to providing responsive outreach child and youth health services to inner-city families experiencing multiple forms of social and material adversity.</p>

Community Health and Resource Directory (CHARD)

With initial funding through the General Practice Services Committee and ongoing funding from the Ministry of Health, CHARD is a directory of regional community health resources and practitioners that covers the entire province. The SSC worked with the Ministry to support the expansion of the directory, which is housed on a secure web-based platform and is only accessible to medical practitioners and their MOAs.

The Ministry worked to populate the directory with specialist physician office listings and, with funding from the SSC, expanded detailed specialist referral information. Providing information on possible specialist subspecialization; providing advanced access for patients; accepting calls for telephone advice; or offering telephone patient follow up services, the directory allows general practitioners and specialist physicians to know in advance who they can call on for advice to manage their patients. The expanded listings also allow general practitioners or specialists to see where they can refer their patients for priority access, and perhaps prevent incorrect referrals with the knowledge of practice specialization (i.e., knowing that an orthopaedic surgeon subspecializes on ankles only).

With the goal of improving access to specialist physicians, the inclusion of a physician's specific referral template form, when available, can be downloaded from CHARD. Having the form available for inquiring practitioners makes the referral process efficient by ensuring specialist physicians receive all required information. This process could also indicate in advance what diagnostic testing could be completed or is most appropriate, thereby reducing demand and preventing duplicate or unnecessary testing and saving costly system resources. A more seamless referral process is more efficient and contributes to a better experience for both patients and providers.

Telehealth

The SSC worked with the BCMA tariff committee to put telehealth consultation and visit fees in place for those specialist sections that agreed to add them to their part of the payment schedule. For the many sections that agreed, fee billing is no longer a barrier to providing this innovative service for those patients unable to see a specialist face to face.

Labour Market Adjustment

The SSC allocated \$10 million for labour market adjustments linked to recruitment and retention pressures. The SSC made clear the funds would be made available to proposed initiatives that demonstrated recruitment and retention pressures, and had processes in place to provide for new fees or initiatives that could be monitored and managed within the fixed amount.

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. In the fall of 2010, after the review process was complete, the advisory group chair presented its findings to the SSC. The SSC accepted the advisory group's recommendations as to which sections met the outlined criteria and awarded funding to the following:

1. Internal medicine
2. Endocrinology
3. Respiratory medicine
4. Infectious disease
5. Rheumatology
6. Obstetrics/gynecology
7. Geriatric medicine
8. Neurology
9. Anesthesiology

The SSC was transparent throughout the process by posting to the SSC website every section submission received, the datasets the advisory group relied upon to help make its recommendations, as well as providing the opportunity for sections to comment on others' submissions. The full report with allocations is available on the SSC website (www.sscbc.ca).

Discharge Planning

The SSC is supporting the work of the Shared Care Committee's Transitions in Care initiative that includes mapping the patient journey into and out of acute care and identifying opportunities to improve patient flow. A mix of hospitals are involved including rural, community, and urban hospitals. The SSC is considering the creation of an interim fee to incent improved communication between hospital specialists and primary care providers to better support patient care.

Pain Management

The SSC supported the BC Pain Society, with sponsorship and planning committee representation on the development and hosting of a provincial summit on pain management.

Specialist Billing Education

The SSC will proceed with the development of billing education tutorial modules for specialist physicians. Health Insurance BC (HIBC) will be engaged to develop messaging on fees, including common incorrectly billed fees, fee issues often requiring manual adjudication resulting in payment delays, as well as the most common fee questions received by HIBC, the Ministry, and the BCMA. Modules for practitioners will be available on the Medical Services Plan MSP Tutor web page (www.health.gov.bc.ca/msp/msptutor/index.html)

Communications

In early 2011, the BCMA began a direct e-mail communication with specialist physicians on SSC initiatives in a newsletter entitled The Specialist Consult. The newsletter reaches over 4000 physicians and is also posted to the SSC's website (www.sscbc.ca).

Patient Reported Outcomes Measures (PROMS)

The SSC was pleased to support a prototype study for orthopedics with the Vancouver Island Health Authority. The study will use existing PROMS instruments to survey patients pre- and post-operatively to capture data about health improvement. The data collection will take place over a two-year period and include about 2000 orthopedic patients.

APPENDIX A: 2012 – Committee Membership Specialist Services Committee Members For the period ending March 31, 2012

BCMA Representatives

Dr Kenneth Seethram (Co-Chair)
Obstetrician/Gynecologist – Surgical Representative

Dr Sean Virani
Cardiologist – Alternatively Paid Representative

Dr Gordon Hoag
Laboratory Medicine – Diagnostic Representative

Dr Ian Courtice
Anesthesiologist – Medicine Representative

Dr Andrew Attwell
Medical Oncologist – Alternatively Paid Representative
(Alternate)

Government Representatives

Ms Nichola Manning (Co-Chair)
Executive Director, Primary Health Care and
Specialist Services Branch – Ministry of Health

Mr Jeremy Higgs
Director, Medical Services Economic Analysis Branch
– Ministry of Health

Ms Effie Henry
Executive Director, Health Authorities Division,
Ministry of Health (Alternate)

Health Authority Representatives

Dr Steve Gray
Vice President, Physician Support Services
Provincial Health Services Authority

Dr Richard Crow
Executive Vice President and Chief Medical Officer
Vancouver Island Health Authority

Dr Jonathan Fenton
Senior Medical Director, Richmond Health Services
Vancouver Coastal Health Authority

Dr Jeremy Etherington
Vice President, Medicine and Quality
Interior Health Authority

Dr Andrew Webb
Vice President, Medicine
Fraser Health Authority

Non-Voting Members

Dr Mark Schonfeld
Chief Executive Officer – BC Medical Association

Ms Sheila Taylor
Assistant Deputy Minister, Medical Services and
Health Human Resources Division

Ministry of Health and BCMA Staff

Ms Nadeen Johansen (Secretariat)
Senior Policy Analyst, Primary Health Care and
Specialist Services Branch,
Ministry of Health

Mr Jim Aikman
Executive Director, Economics and Policy Analysis –
BC Medical Association

Dr Sam Bugis
Executive Director, Physician and External Affairs –
BC Medical Association

Mr Peter McClung
Health Economist, Economics and Policy Analysis –
BC Medical Association

Mr Adrian Leung
Senior Analyst, Economics and Policy Analysis –
BC Medical Association

Ms Sharon Shore
Senior Manager, Communications and Media
Relations – BC Medical Association

Ms Andrea Elvidge
Executive Director – Society of Specialist Physicians
and Surgeons of British Columbia

Mr Clay Barber
Consultant

APPENDIX B:

Excerpts from the Specialists Subsidiary Agreement

ARTICLE 4 – COLLABORATION WITH SPECIALIST PHYSICIANS

- 4.1 The Government and the BCMA agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients' medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options and health human resource options.

ARTICLE 5 – SPECIALIST SERVICES COMMITTEE

- 5.1 A Specialist Services Committee shall continue under this Agreement to facilitate collaboration between the government, the BCMA, and the health authorities on the delivery of services of Specialist Physicians to British Columbians and to support the improvement of the specialist care system.
- 5.2 The government and the BCMA shall each appoint an equal number (not to exceed four each) of members to the Specialist Services Committee.
- 5.3 The Specialist Services Committee will be co-chaired by a member chosen by the government members and a member chosen by the BCMA members.
- 5.4 Decisions of the Specialist Services Committee shall be by consensus decision.
- 5.5 If the Specialist Services Committee cannot reach a decision on any matter that it is required to determine under section 5.6(a) or section 5.6(b), the BCMA and/or the government may make recommendations to the MSC and the MSC, or its successor, will determine the matter. If the Specialist Services Committee cannot reach a consensus decision with respect to any matter that is referred to it under section 5.6(f) and that requires a determination, the Physician Services Committee will determine a process for resolving the dispute, which may include referral to the Adjudication Committee or the MSC.
- 5.6 The Specialist Services Committee will have the following responsibilities:
- (a) allocating funds referred to in Article 6;
 - (b) allocating funds referred to in Article 7;
 - (c) identifying possible time limited projects that have measurable patient-centred goals focused on the following areas:
 - (i) system redesign initiatives to achieve increased and faster access to medically needed surgical specialist assessment for hip, knee and other joint replacement; and
 - (ii) working with the General Practice Services Committee and based upon patient needs, determining up to four other non-surgical priority areas to expedite access to assessment and treatment for specialty care;
 - (d) creating a surgical specialist sub-committee to work with Health Authorities and the Ministry to analyze and make recommendations to reduce the number of urgent and elective surgeries occurring outside of normal working hours, in particular between 10PM and 6AM;
 - (e) consulting with representatives of allied health professionals as necessary in the completion of its mandate; and
 - (f) other matters that may be referred to it by the Physician Services Committee.

- 5.7 On an annual basis, the Specialist Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report on progress and outcomes to the Physician Services Committee.
- 5.8 The costs of administrative and clerical support required for the work of the Specialist Services Committee and physician (other than employees of the Government, BCMA, and Health Authorities) participation in the Specialist Services Committee, will be paid from the funds referred to in section 6.1 of this Agreement, such costs not to exceed \$400,000.

ARTICLE 6 – DISPARITY CORRECTION FUNDING

- 6.1 The Government has increased annual funding by \$13 million in the Fiscal Year commencing on April 1, 2006 and an additional \$7 million in the Fiscal Year commencing on April 1, 2007, such increases to be used to address income disparities among Specialist Sections. This \$20 million aggregate increase in annual funding will be combined with the \$10 million annual funding previously made available pursuant to article 5.1 of the 2004 Subsidiary Agreement for Specialists, to create a total allocation effective April 1, 2007 of \$30 million to address disparities between Specialist Sections.
- 6.2 The specific allocation of the funding referred to in section 6.1 will be determined by the Specialist Services Committee and will be based upon the Modified Adjusted Net Daily Income (the “MANDI”) model (...) or a revised version of the MANDI as agreed to by the Specialist Services Committee.
- 6.3 The general compensation increases to Fees that are identified in sections 1.1(b) and 1.2(a) of Appendix F to the Physician Master Agreement will be applied to Fees for the Specialist Sections prior to the application of the disparity correction funding pursuant to section 6.1. In other words, such disparity correction funding will not attract the general Fee increase in the year in which such disparity correction is introduced. The base years for application of the disparity correction funding will be the Fiscal Year commencing on April 1, 2005, for corrections introduced on April 1, 2006 and the Fiscal Year commencing on April 1, 2006 for corrections introduced on April 1, 2007.
- 6.4 Compensation adjustments resulting from section 6.1 will be effective on April 1, 2006 and April 1, 2007, as appropriate.

ARTICLE 7 – FUNDING FOR MEDICAL CONSULTATION SERVICES

- 7.1 The Government has increased annual funding by \$1 million in the Fiscal Year commencing on April 1, 2007, and will increase annual funding by an additional \$1 million in the Fiscal Year commencing on April 1, 2008, and a further additional \$2 million in the Fiscal Year commencing on April 1, 2009, to be allocated by the Specialist Services Committee to Health Authorities to contract (using Alternative Payment Arrangements) specific services from medical consultants to support primary care for specific patient populations (including populations at risk) and those with complex problems such as chronic conditions, mental illnesses, addictions and disabilities.

ARTICLE 11 – DISPUTE RESOLUTION

- 11.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 21, 22, and 23 of the Physician Master Agreement applicable to Provincial Disputes.

Full agreement available at:
www.health.gov.bc.ca/msp/legislation/pdf/APPENDIX_B_Specialists_Subsiary_Agreement.pdf

APPENDIX C:

Excerpts from the 2009 Memorandum of Agreement

2.02 Funding to Improve Access to Specialty Services by British Columbians

The Government will increase the funding allocation to the Specialty Services Committee (the “SSC”) to support its work in enhancing and expanding the programs that support the delivery of high quality specialty services to British Columbians by, amongst other things, expediting access to specialist consultations, treating patients and communities with unmet needs by, amongst other things, supporting the provision of complex and/or chronic and indirect/remote care, expanding clinical prevention activities by specialists and making labour market adjustments where required to recruit and retain specialists in British Columbia.

The increased funding will be in two allocations:

- a. April 1, 2010: \$20 million per year
- b. April 1, 2011: an additional \$25 million per year

Up to \$30 million of these funds are available for labour market adjustments. The base year for the application of labour market adjustments will be the fiscal year 2009/10 for changes made April 1, 2010 and fiscal year 2010/11 for changes made April 1, 2011.



**SPECIALIST SERVICES
COMMITTEE**

SPECIALIST SERVICES COMMITTEE
115 – 1665 West Broadway
Vancouver, BC V6J 5A4
www.sscbc.ca