

REPORT OF THE
MOCAP REDESIGN PANEL

appointed under Section 17.4 of the
2012 Physician Master Agreement

to the

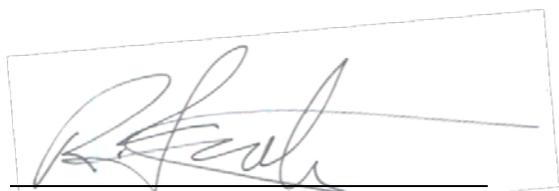
Physician Services Committee

May 14, 2013

Re: MOCAP Redesign Panel

We are hereby forwarding to you our Report with respect to our recommendations with respect to the redesign of the Medical On-Call/Availability Program. We are pleased that we are able to forward a report to you which has been agreed to by all members of the Panel.

We deliver this Report to you in the hope that it will be found acceptable by your Committee and that, as a consequence, steps will be taken to improve MOCAP to better meet the interests of patients, physicians, Health Authorities and Government.



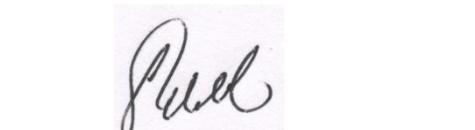
Rod Frechette



Dr. Randy Moore



Eric J. Harris, Q.C., Chair



Dr. Andrew Webb



Dr. Ahmer Karimuddin

I. INTRODUCTION

This has been the first opportunity to review thoroughly the experience gained through MOCAP since it was established in British Columbia in 2002. Other reviews have been conducted, but not to the extent of receiving submissions directly from many physicians and physician groups as well as from Health Authorities. We were directed to consider changes to be made to MOCAP, rather than just to conduct a review of the existing program.

The MOCAP Redesign Panel considers it to have been a privilege to participate in this process and to listen to the experience of many physicians and health care administrators gained during the past 10 years of MOCAP. If this Report has captured the way to move forward with MOCAP, much of the credit goes to those who chose to meet with us and to share their views.

We also are grateful to Dr. Sam Bugis who provided us with support on behalf of the BC Medical Association, and Dr. John Maynard and Abigail Pittman who provided us with support on behalf of the Ministry of Health and the Health Authorities.

II. JURISDICTION

The MOCAP Redesign Panel was created by Section 17.4 of the 2012 Physician Master Agreement. The provisions of that section are attached to this Report as Appendix 1.

In accordance with that section, the BCMA appointed Dr. Ahmer Karimuddin and Dr. Randy Moore to the Panel. The Government appointed Rod Frechette and Dr. Andrew Webb to the Panel and Eric Harris was appointed Chair.

The Panel held a number of meetings to determine the issues that have arisen under MOCAP and then developed a Discussion Paper which was distributed to all physician sections in the BCMA and Health Authorities. The Discussion Paper was also made available to individual physicians.

The Panel held meetings on January 21, 23, 25 and 29, 2013 at which time it heard from twenty-six representatives of Health Authorities and physician sections of the BCMA. The Panel also received written submissions from sections who did not meet with us and a further eighteen individual physicians explaining their unique circumstances. We also received separate submissions on the issues of rural and Alternate Payment issues.

As a consequence, we consider we have received reliable information on the operation of MOCAP from both urban and rural settings and from the point of view of physicians and administrators who work in both large complex organizations as well as in small health facilities.

III. HISTORY OF MOCAP

In this section of our Report we will describe the history of MOCAP to assist in understanding the origins of MOCAP and the experience of the parties since its creation. While experiences in other jurisdictions were considered, MOCAP was the result of intensive negotiations during a period of conflict between the Profession and the Government.

We also hope that describing the history will demonstrate that on four occasions, the parties have contractually intervened in a significant way with the MOCAP program. In 2007, the parties agreed to conduct a MOCAP review. Subsequently, in 2008 the parties established MOCAP distribution and dispute processes. In 2010, these latter processes were suspended, and in 2012 our Panel was established.

The Dobbin Report

The history begins in 1998 when there began a process of profound change in the provision of care ultimately leading to the adoption of MOCAP.

In April of 1998, Lucy Dobbin was requested by the Ministry of Health to examine the causes of difficulties which had developed between certain general practitioners in northern and rural communities and Health Boards. She was also requested to make recommendations to resolve such difficulties. At page 4 of her Report she stated:

In January of 1998 a significant number of physicians in some northern, rural communities of the province began to withdraw their "on call" services at the local hospitals. These initial actions were joined at later dates by physicians in other rural areas of the province. Most actions resulted in physicians being available in clinics during the day and on call for the community during off hours but resigning their hospital privileges and being on call for hospital emergencies only of a "life or limb threatening" nature.

In her Report, Ms. Dobbin considered the differences between rural physicians and urban physicians. In particular, she emphasized the fact that in smaller rural communities there are fewer physicians and, therefore, a heavier call burden. The difficulty of obtaining locums and the absence of a broad range of specialist services were also reflected in her Report.

Ms. Dobbin made 21 separate recommendations, related to access to Continued Medical Education by rural physicians, methods to enhance recruitment and retention of physicians to rural areas, the availability of alternative methods of payment for physicians in remote areas and the expansion of the role of rural nurses. Of particular relevance to our work she recommended for the first time in British Columbia that northern and rural general practitioners specifically receive compensation for being on call.

Accepting the recommendations in Ms. Dobbin's report, the Government established the Emergency Medical Coverage Program in 1999. It resulted in the first payments made for on-call/availability services for physicians practicing in Northern Isolation Allowance (NIA) communities.

In early 2000, the Government and the BCMA agreed in a Framework Memorandum that on-call issues would be a subject for negotiations in the 2001 Working Agreement. The Framework Memorandum also provided for negotiations to establish the first Rural Subsidiary Agreement (RSA) between the Government and the BCMA. In June 2000, agreement on the first RSA was reached.

The RSA included provisions for on-call payments for physicians practicing in Northern and Isolated communities, incorporating such payments in a provincial agreement for the first time. Amongst the changes in on-call payments provided for in the RSA was the extension of on-call payments to specialists in the NIA communities.

The Prince George and Williams Lake Agreements

Subsequent to the ratification of the RSA, physicians in Prince George and Williams Lake began to withdraw certain medical services. As a consequence of these difficulties, agreements were entered into in the summer of 2000 which provided for recruitment initiatives, an expansion of Continuing Medical Education, retention incentives and other benefits. Of particular relevance to our work, these agreements also included payments for specialists providing on call services to hospitals.

These agreements prompted physicians in other rural and small urban communities to withdraw services or threaten to withdraw services. In response to such actions, the Government established the Physician Recruitment and Retention Program which amongst other things, extended on-call payments to physician practicing in all rural and small urban communities throughout BC and the Interim Urban Specialist Availability Program which extended on-call payments to certain specialty groups in urban communities.

Provincial Negotiations in 2001

The Working Agreement between the BCMA and the Government expired on March 31, 2001. Negotiations failed to result in a renewal of the Agreement and the matter was submitted to arbitration. On February 8th, 2002 the Arbitration Board chaired by Chief Justice Alan McEachern published its initial award.

The Arbitration Board was asked by the parties to answer a series of specific questions including questions related to payment for providing on-call/availability. The BCMA proposed a rate per hour which changed for different hours of the week. For example, \$20 per hour for 0800 to 1700 Monday to Friday, \$30 per hour for 1700 to 2300. The BCMA argued that any physician who

provided call services should be paid the same. The Government proposed a fund of \$66.6 million to pay for all call services in the Province. The Government proposed that there would be three tiers of call as follows:

Tier 1 – on site continuous coverage

Tier 2 – continuous coverage

Tier 3 – scheduled second call for emergency availability when first call is already engaged.

The Arbitration Board awarded on an interim basis that 75% of the rates proposed by the BCMA would be implemented for general practitioners while rural and specialist physicians would be paid 100% of the rates proposed by the BCMA. The Board left for further consideration the issues of creating differentials within call rates.

The 2002 Agreement

On March 7, 2002, the Government passed legislation to end the binding arbitration process, to eliminate any further binding arbitration proceedings and to strike down the arbitration award.

Following the Government's legislative intervention, the BCMA and Government signed a Memorandum of Understanding, which amongst other things, identified the funding that would be made available for on-call payments in a new Working Agreement.

Within a highly charged environment, the Government and BCMA then negotiated a new agreement that was ratified on July 16, 2002.

The 2001 Working Agreement was entered into for the term of April 1, 2001 to March 31, 2004 and was made as of November 4, 2002.

Article 6 provided for retroactive on-call availability payments as follows:

"6.1 Eighty million dollars in retroactive on-call/availability payments, to cover the period April 1, 2001 to March 31, 2002, will be paid in the following manner:

- (a) The retroactive on-call/availability money will be distributed by the health authorities;
- (b) Subject to article 6.6, retroactive on-call/availability payments will be valued as follows:
 - (i) General practitioners who are practising in communities included in the Subsidiary Agreement for Physicians in Rural Practice and Specialists
 - Mon. – Fri. 0800 – 1700 \$20/hr
 - Mon. – Fri. 1700 – 2300 \$30/hr
 - Sat./Sun. 0800 – 2300 \$30/hr
 - Mon. – Sun. 2300 – 0800 \$40/hr

- Stat Holidays 0800 – 0800 \$40/hr
- (ii) All other physicians: 75% of the above rates
- (iii) When the Physician was required to provide the on call coverage on-site the rate will be increased by 50%."

Article 7 provided for the new on call availability program as follows:

- 7.1 The on-call/availability program will be effective April 1, 2002, and will provide payment to physician(s) and physician groups who provide coverage for patients, other than their own or their call groups, as required and approved by health authorities.
- 7.2 The total amount for on-call/availability programs is \$125 million annually for the April 1, 2002 to March 31, 2003 and the April 1, 2003 to March 31, 2004 periods.
- 7.3 The on-call/availability program will replace all existing on-call/availability arrangements.
- 7.4 Where on-call/availability is required it is in the best interests of the population served that it be provided on a 24/7/52 basis. It is recognized that, in some circumstance, a Health Authority may decide to provide on-call on some other basis.
- 7.5 On-call/availability arrangements will be provided by agreement/contract between physician groups and health authorities.
- 7.6 The Government and the BCMA agree to meet within 60 days of the signing of this Agreement to discuss the creation of an on-call template agreement.
- 7.7 On-call/availability payments will be determined on the basis of annual rates.
- 7.8 There will be different annual rates for services provided by call-groups. The annual rates for 2002/03, 2003/04 will be categorized as follows:
 - (a) Level 1 – Coverage designated by a Health Authority to require availability by telephone within 10 minutes, and available to be on-site urgently but no later than within 45 minutes. The annual rate for 24/7/52 Level 1 coverage is \$225,000 per call group.
 - (b) Level 2 – Coverage designated by a Health Authority to require availability by telephone within 15 minutes, and available to be on-site within 2 hours. The annual rate for 24/7/52 Level 2 coverage is \$165,000 per call group.
 - (c) Level 3 – Coverage designated by a Health Authority to require availability by telephone within 15 minutes, and available to be on-site within 16 hours of receiving the call. The annual rate for 24/7/52 Level 3 coverage is \$70,000 per call group.

- (d) On Site On-Call – Where a physician is designated by a Health Authority to be on-call on site. Physician groups in this category predominately include tertiary obstetrics, anesthesia, and neonatology. The annual rate for 24/7/52 on-site on-call coverage is \$325,000 per call group.
- (e) Call Back – Where a physician is not on-call but is called-in by the Health Authority to provide a service. The call back rate is \$250 per call-back.

7.9 On-call/availability arrangements should be sustainable and therefore must not contribute to physician burnout.

7.10 If the total expenditure for on call services provided in 2002/03 is less than \$125 million, the future on call rates will be adjusted upwards by the amount of the under expenditure.

Our Panel was able to talk to individuals who were directly involved in the negotiation of this Working Agreement. It appears clear that Article 7 and the Levels established were not based on experience from other jurisdictions or from any study of how availability might work. Rather during intensive negotiations, it was accepted as a reasonable way to differentiate the levels of call based on the time to respond on-site which was primarily a reflection of the urgency of a patient's medical condition.

From the inception of this program, it was made clear in Section 7.1 that on-call/availability payments were based on the provision of care for patients who are not already cared for by the physician or their call group and also that the nature and extent of the coverage to be provided was for the Health Authorities to determine. The Agreement also provided that a physician not on call but called back to provide a service would receive a payment. As contemplated by Section 7.6, the Government and BCMA subsequently agreed upon a template contract to govern MOCAP payments and that template contract (with minor amendments) continues to be used for that purpose. The total cost was not to exceed \$125 million dollars for each of the first three years of the program.

The 2004 Agreement

The parties then entered into a further Working Agreement for the term of April 1, 2004 to March 31, 2007, which continued MOCAP largely on the same terms. Article 5 of this Agreement provided that the budget of \$125 million would continue for each year of the Agreement but for the first time, Doctor of the Day services were included in the MOCAP budget. The Levels for on call remained unchanged and the payments for each Level also remained unchanged. The call-back program was also unchanged.

The 2006 Agreement

The 2004 Working Agreement contemplated that compensation changes and other issues could be adjusted effective April 1, 2006 and set out a process to settle those issues. As a consequence, the parties entered into a further agreement dated April 1, 2006 to establish the compensation and related issues for 2006/2007 and for subsequent years up to and including 2011/2012.

The 2006 Agreement provided in Section 5.3 for a review of the MOCAP program as follows:

5.3 The Medical On-call/Availability Program

- (a) A tripartite review team, composed of nine members with three members appointed by each of the Government, the BCMA and the Health Authorities, will conduct a review of the MOCAP as described in section 5.3(b);
- (b) The tripartite review team will:
 - (i) evaluate the impact of MOCAP on patient care, physician work life and other health professionals;
 - (ii) where problems are identified, recommend solutions, mechanisms and/or alternatives (including redistribution or reallocation of MOCAP funding) to effect greater patient access to time emergent care, to address inequities in MOCAP implementation, and to increase value to patients and the public, within the MOCAP budget allocation;
 - (iii) establish indicators to monitor and track MOCAP performance and set out evaluation criteria;
 - (iv) deliver a report to the Government, the BCMA and the Health Authorities by December 31, 2006, as the basis for changes or modifications, new mechanisms and/or allocations within the existing MOCAP budget; and
 - (v) conduct an evaluation of the changes implemented pursuant to section 5.3(b)(iv) and recommend appropriate further revisions to the MOCAP to the Government, the BCMA and the Health Authorities by April 1, 2009.
- (c) Any changes to the MOCAP provisions of the 2004 Working Agreement resulting from any recommendations made pursuant to section 5.3(b)(iv) or section 5.3(b)(v) will require the agreement of the Government and the BCMA.
- (d) For each of the Fiscal Years from April 1, 2006 to March 31, 2012, the budget for the MOCAP will be maintained at the current level of \$126.4 million annually.

The MOCAP Review Team

As contemplated by the 2006 Agreement, the MOCAP Review Team was established consisting of nine members.

The Team reviewed certain Reports provided by Government on various aspects of MOCAP and in its report dated January 15, 2007, noted at page 2:

The MRT recognizes that the MOCAP Program has produced positive results for the health care system. It has improved the ability of the HA's to maintain an effective call schedule and helped to address recruitment and retention issues in key areas. For the majority of physicians on MOCAP, the program is working very well and offers important recognition and payment for on-call availability. However, MOCAP is not without problems. The available data demonstrates that the status quo is not financially sustainable.

The Team then summarized the established Principles of MOCAP as follows:

The MRT has identified the following principles within the existing program:

- 3.1 MOCAP is designed to meet the medical needs of new or unassigned patients requiring emergency care. By definition, a new or unassigned patient is not a patient of any physician participating in the call group.
- 3.2 MOCAP provides compensation for physician availability, which is structured by the HAs to reflect patient needs. MOCAP is not meant to pay for physician services to patients.
- 3.3 MOCAP arrangements must be sustainable, and therefore, must not contribute to physician burnout.
- 3.4 HAs require some flexibility in MOCAP administration due to variations in size and role of facilities within different HAs. However, decisions on MOCAP must be applied consistently, reflecting a similar rationale in all HAs.
- 3.5 Although three of the payment levels within MOCAP are structured based on physician response times, actual response times are based on individual patient need, on a case-by-case basis.

The Recommendations of the Team are found at Appendix 2.

We understood the recommendations of the MOCAP Review Team were circulated to all of the parties, but we have been unable to determine whether the recommendations were fully implemented.

Physician Master Agreement with Amendments

As contemplated by the 2006 Agreement, the parties entered into a new Physician Master Agreement effective November 1, 2007 (the "PMA"). Subsequently a number of amendments to the PMA were agreed upon.

The provisions of MOCAP established the budget for each year from April 1, 2006 to March 31, 2008 as \$126.4 million annually. New MOCAP provisions were agreed upon, including:

- A requirement that the Health Authorities distribute their MOCAP funds in a manner that met certain stated objectives
- A requirement for the development, by the MOCAP Advisory Committee, of evaluation criteria that supported the distribution objectives
- A process governing the creation of annual distribution plans for MOCAP funding by Health Authorities, including the use of a MOCAP Contract Review Committee ("MCRC") with physician representation in the planning process, and
- A process for resolving disputes ("MOCAP Distribution Disputes") by physicians regarding the application of the evaluation criteria and/or the distribution process.

The MOCAP Advisory Committee consulted with the BCMA on the evaluation criteria and in January 2008 finalized a set of criteria. The evaluation criteria emphasized that:

- MOCAP operates with the context of the MOCAP Policy developed over time by the MOCAP Advisory Committee
- The health authorities are ultimately responsible for managing within their MOCAP allocations and that the decisions as to the specific nature and quantity of on call availability services required rest ultimately with the health authorities
- The health authorities require flexibility in MOCAP administration but that there should be a consistent rationale underlying MOCAP decisions
- MOCAP is intended to meet the needs of new or unassigned patients (i.e., a patient that is not a patient of the participating physicians)
- MOCAP compensates for availability and is not meant to pay for the actual services provided to patients or to compensate physicians who are otherwise compensated to be available
- MOCAP arrangements should be sustainable and not contribute to physician burn out

- Individual patient needs dictate actual response time requirements, and
- Physicians participating in MOCAP must be available for all on call needs as designated by the health authority.

The parties ultimately determined that it would not be possible to meet all the deadlines set by the new MOCAP distribution and dispute processes, and they eventually agreed to extend some of the deadlines for the fiscal years 2008/09 and 2009/10. In addition, differences arose between the Government and the BCMA regarding the meaning of some of the new MOCAP related provisions of the PMA and as a result, the provisions were amended effective June 12, 2008. It was at this time that the reference to the annual MOCAP budget was removed leaving the decision to Government as to how much money would be provided annually for MOCAP.

In the spring of 2010, during the course of proceeding with the first MOCAP Distribution Disputes, further differences arose between the Government and the BCMA regarding the meaning of some of the new MOCAP related provisions of the PMA. The parties subsequently entering into a Memorandum of Agreement as of July 23, 2010 resolving the consequences of certain decisions made by the MOCAP adjudicator under the MOCAP Distribution Disputes process. The Memorandum also suspended the dispute process and provided that there would not be any further decisions made by the MOCAP adjudicator. The Memorandum also confirmed a number of settlements of MOCAP issues in different Health Authorities.

The parties also agreed to suspend the operation of the new MOCAP distribution and dispute processes for the fiscal years 2010/11 and 2011/12.

What is significant to our Panel is the attempt by the parties to define a process to adjudicate disputes with respect to the allocation of MOCAP funds within a fixed budget failed.

The 2012 Physician Master Agreement

A new Physician Master Agreement was entered into as of April 1, 2012 (the "2012 PMA"). As described in section 2 of this Report, the 2012 PMA established the responsibility of our Panel to redesign the MOCAP process.

While the new MOCAP distribution and dispute resolution processes that were originally introduced in the 2007 PMA were continued in the 2012 PMA, the 2012 PMA also provided that those processes would remain suspended until July 1, 2013, when they would revive for application to the fiscal year 2014/15 unless the Physician Services Committee accepts the recommendations of the MOCAP Redesign Panel.

IV. CONCERNS WITH RESPECT TO MOCAP

Many physicians and physician groups informed us that MOCAP as it is currently administered is working well and should not be disturbed. Other physicians and physician groups made suggestions to us for changes to the Program. The representatives of Health Authorities all made recommendations to us supporting change. In the course of listening to these different positions we tried to determine what concerns or issues existed which would justify the redesign of MOCAP.

Our abiding impression was that the significant majority of physicians support the continuation of MOCAP in some form and none of those who communicated with us felt that it was feasible to discontinue the program. In fact, the general view is that payment for being on call for patients other than the physician's own patient is now a permanent feature of physician compensation in the Province.

In light of the foregoing and from the personal experience of the Panel, we have approached our task on the basis of what changes to MOCAP should be made that will improve the accountability and performance of the Program. In order to determine what will improve the Program we first had to determine the concerns that existed with the current Program.

Therefore, we are setting out below the primary concerns that exist with the Program:

1. Lack of clarity about the purpose of the program.

Many physicians informed us that it was their understanding that the Program resulted in payments for physicians being available to meet the medical needs of new or unassigned patients requiring emergency care. Some of those physicians described that they were paid at a particular MOCAP level because of the "length of the leash" which tied them to hospitals while on call.

Other physicians suggested that there was "hard" call and "easy" call as the burden of call was different for different physician groups. For example, it is not uncommon for certain physicians to suggest that "hard" call can be demonstrated by the number of nights that a physician's car can be found in the car park at a hospital.

2. Lack of clarity about obligations while on call.

The concept of being on call raises the question of who a physician on call is required to respond to. Is it just the facility where the physician has privileges and is described in a MOCAP contract, or is there a responsibility to respond to other physicians and facilities? Some physicians consider themselves only responsible to a particular facility, whereas other physicians consider they must respond to calls from other locations.

It is clear that the Program was designed so that physicians would be paid for being available, as required by the Health Authority to respond to the emergency care needs of patients other than their own or their call group's. The Program was not designed to pay physicians to be available for their own patients.

There also may be some confusion on the duty of physicians on call for Provincial tertiary facilities.

3. Lack of clarity about complying with response times.

Certain stakeholders in the system are emphatic that physicians on call must be on site within the times established by the levels of call. Most physician groups take the view that responding within those time limits on some occasions may be clinically unnecessary, for instance if a patient is stable and may be seen at a later time.

This issue also gives rise to the concerns of certain stakeholders who are responsible for the "flow" of patients through Emergency Departments or who are responsible for reducing patient overcrowding in the Emergency Departments. This is a consideration that has grown in importance over the last years both for financial reasons as well as for clinical outcomes.

It is also evident there are locations in the Province where the time limits established for the Levels of call are not enforced in any way.

4. The time frame to respond may be inappropriate.

We heard from certain physicians who are engaged in, for example, coronary care or obstetrics, who informed us that they must respond in a shorter time frame than expected by the Levels. Some physicians must respond immediately and others may not be needed as urgently.

5. The problem of enforcement.

We heard from some administrators and physicians who have found it difficult to address the issue of an individual physician who is on call and who repeatedly is reluctant to respond to call. Some administrators and physicians are unclear as to what process to follow to address such behaviour.

6. The Burden of Call.

We received submissions that a physician on call who is called frequently during the night, who has to attend to very acute illnesses or injury that involves intensive care or procedures should be rewarded differently in call payments from a physician who is called infrequently and whose involvement may be less intensive and time consuming.

Other physicians took the view that physicians who are called in receive the benefit of additional payment through fees or other payments. Those physicians argue that the system already provides payment for heavier call and that call levels should not be changed.

7. Lack of clarity about the classification of call.

Most physicians and administrators acknowledged there is a lack of data available to determine what work is done when physicians are on call. It also became clear that many of the disputes that have arisen relate to differences between a Health Authority and a group of physicians about the level of call or whether the physicians should be on call at all.

Some groups of physicians have taken the position that their services are not properly “valued” or they have been treated with disrespect by being offered a lower level of call than they believe is warranted. It appears that some physician groups in both the urban and rural environment have migrated upwards in their level of call solely due to disputes of this nature.

The creation of data on which to base on-call payments is regarded with some suspicion by some physician groups as to whether the data would capture the full level of activities of a physician on call, or conversely may overvalue certain activities.

8. Is there a difference between urban and rural call.

The submissions we received were mixed on this issue. Rural administrators and rural physicians generally took the view that it is important to preserve the fact that the aggregate of payments received by rural physicians are an important recruitment and retention tool. In that respect, MOCAP might be seen as partial retention compensation rather than purely payment for being on call and it may be that the levels are more generously granted in rural areas.

Other physicians, rural and otherwise, consider that MOCAP proper should be governed by Provincial standards and be consistently applied across all Health Authorities. These views were expressed by physician groups which may have call groups recognized in certain Health Authorities but not in other Health Authorities.

We received certain submissions that there may be other justifications for looking at rural call separately from urban call. For example, physicians in rural areas often have to travel significant distances to provide services. There was some view that this would justify additional payment. Other physicians pointed out that in the rural area, while physicians may be called frequently, the intensity of the work is lower.

9. There is confusion about how general practitioners may be eligible to participate in MOCAP.

We received submissions that general practitioners who provide such services as anaesthesia, surgical, paediatrics, obstetrics, residential care, community GP out of hours, in-hospital coverage and emergency services may not be funded in a consistent manner across the Province.

10. Call back payments.

We heard the general refrain that call back payments are not working as it is difficult to have the services authorized and certain administrators limit the number of call backs permitted within a certain period. Other specialist physicians such as surgeons pointed out to us that certain physicians called back to perform, for example, surgical assist, could be called back on a number of occasions such that they can achieve higher earnings than the surgeon performing the surgery.

It is also plain that surgeons often find it difficult to have the necessary support from surgical assistants. In most cases these assistants are not obliged to attend at the facility to assist in an operation.

11. Can physicians be on call for more than one facility?

Certain physicians provide call and services at more than one facility. Others arrange for patients to be transferred to the facility for which they are on call to receive services.

We also were informed that many physicians receive a significant number of telephone calls related to emergent or urgent situations. The physicians often find it difficult to bill for those telephone consultations or the rules for such billing may not allow them to bill.

12. There can be multiple call groups in a geographic area.

The concern has been raised by administrators that there are circumstances where call groups should be limited to certain facilities in a geographic area. Those concerns relate to the issue of whether or not call groups should be created at every site where patients may present themselves on an emergent basis or whether the provision of after-hours services should be conducted only at specific sites.

13. New technology has changed MOCAP.

It is obvious that new technology is assisting physicians in ways which did not exist when MOCAP was designed. For example, radiologists on call can often provide their services without leaving home. This is because of the PACS technology makes the necessary data available directly to the radiologists in their homes.

14. Consultative mechanisms have broken down.

We heard a number of views that the previous consultative methods through MOCAP Advisory Committees and MOCAP Contract Review Committees are unfortunately suspended at the present time. It appeared to be the universal view of those who spoke to us that the active presence of those committees was helpful in the management of MOCAP.

15. Dispute resolution is not working.

Since the suspension of the MOCAP Dispute Resolution Process, local disputes on MOCAP have to be resolved locally. Some disputes remain unresolved. Most submissions we received were clear that a workable dispute resolution process should be available if the consultative processes do not result in resolution.

16. The MOCAP budget is inflexible.

A number of physician groups as well as Health Authority representatives were concerned that MOCAP will not work unless the budget accommodates new programs and changed circumstances. A fixed MOCAP budget is resulting in difficulties for Health Authorities to manage. The problem is which call group should be downgraded or discontinued to accommodate a new call group or one at a higher level.

17. There is a concern about prorating MOCAP payments.

We have received submissions that the prorating of MOCAP payments, in some circumstances, have caused tensions in the system.

V. RECOMMENDATIONS

1. Principles

We have listened to a number of conflicting explanations of the purpose of MOCAP. We therefore consider it important that the purpose of MOCAP be explicitly restated as a touchstone for decisions to be made in the future and to assist in resolving any disputes that may arise.

We have reviewed the MOCAP Policy Framework for Health Authorities as published by the Ministry of Health Services on July 6, 2004 as well as the Report of the MOCAP Review Team dated January 7, 2007 and the evaluation criteria referred in section 17.3 (b) of the 2012 Physician Master Agreement. We rely, in part, on the principles those documents established. We recommend the parties explicitly adopt the following principles for MOCAP:

- (a) MOCAP is designed to meet the medical needs of new or unassigned patients requiring emergency care. By definition, a new or unassigned patient is not a patient of any physician participating in a call group.
- (b) The health authorities are responsible for managing within their MOCAP allocation and decisions as to the specific nature and quantity of on-call availability services required rests ultimately with the Health Authorities. A Health Authority's decision to establish a MOCAP arrangement is made following consultation with physicians.
- (c) MOCAP arrangements may require availability to attend more than one site where clinically appropriate and may permit the availability to be provided in a manner consistent with advancements in technology.
- (d) MOCAP provides compensation for physician availability including the relative burden of providing such availability. MOCAP is not meant to compensate physicians for actual services to patients.
- (e) Physicians who are on call must respond to telephone calls in a timely way to determine clinical urgency and attend to the emergent needs of patients.
- (f) Physicians who are on call must respond to telephone calls not just from the location(s) where they are on-call for, but from other locations and physicians.
- (g) Payments for being on call should be based on objective data and information that reflect the burden of providing on-call services and may vary from location to location based on the particular circumstances present. However, decisions on MOCAP should reflect a consistent rationale across all Health Authorities.

- (h) MOCAP arrangements must be sustainable, and therefore must not contribute to physician burnout. In some circumstances, physicians may provide partial on-call availability to meet this principle.
- (i) Health Authorities must appropriately fund the call groups that are established under the Program. Health Authorities should not prorate MOCAP payments (i.e., pay a lesser amount for the coverage required than is appropriate) in order to try to “extend” their MOCAP budget.
- (j) There are separate and independent obligations through Health Authority by-laws and rules and the College’s professional standards that require physicians to provide call including call for new and unassigned patients. When a Health Authority requires physicians to provide call for new and unassigned patients, the Health Authority will provide payment under MOCAP in accordance with the PMA.

We also recommend the Physician Master Agreement, the MOCAP Policy, the evaluation criteria, and the template contract (if a contract is going to continue to be used) be revised as to reflect these principles and the balance of our recommendations.

2. Provincial MOCAP Review Committee

We recommend that a Provincial MOCAP Review Committee be created immediately.

The Committee would be responsible to:

- Oversee the transition to the redesigned system,
- Approve the allocation of points as described in Recommendation 4,
- Ensure consistent approaches between Health Authorities,
- Approve annual distribution plans under Recommendation 5, Approve any exception under Recommendation 6,
- Resolve any disputes under Recommendation 8, and
- Conduct an evaluation of the effectiveness of the new system under Recommendation 9.

We recommend that the Ministry appoint three representatives to the Committee (including any representatives of Health Authorities) and the BCMA appoint three physician representatives. An independent Chair should be selected for the Committee.

In light of the important continuing role of the Committee, we recommend that the parties appoint senior representatives to the Committee who possess experience in the operation of MOCAP.

3. Transitional Issues

The process we are recommending to establish a new method of determining on-call payments may take a number of months to complete. Additionally, we consider that the implementation of a recommendation should proceed in an orderly manner over time.

We therefore recommend:

- (a) Subject to (b) below current on-call arrangements should continue in effect until those arrangements are modified through the new process.
- (b) During the period necessary to implement the recommended changes, only minimal changes to call groups will be made.
- (c) The Provincial MOCAP Review Committee should both guide the implementation and approve changes to call groups during the transition. Where there are disputes during the transitional period, the Provincial MOCAP Review Committee should resolve such disputes.
- (d) Once the new process is finalized, on a continuing basis either a call group or Health Authority may provide notice to the other party of their wish to review the existing arrangements.
- (e) Any changes in the payment level for call groups arising from such a review would be effective after expiration of the term notice period in existing MOCAP contracts.

4. Data Requirements

As we have stated earlier in our Report, we believe improving the operation of MOCAP and reducing the number of disputes requires making more objective decisions about the burden of MOCAP and the resulting payment levels.

We have concluded physicians should be compensated for being available to meet the needs of new or unassigned patients requiring emergency care, but compensation should be based on the impact of being on-call on the physician and on their normal practice. After a great deal of discussion, we have concluded the following factors should be taken into account:

- (a) Frequency of telephone calls while on-call and the time of day when telephone calls are received;
- (b) Frequency with which physicians must return to their site of work (or alternate sites to provide call) and the time of day when such returns must occur;
- (c) Average time taken to attend to emergent calls from midnight until 7:00 am;
- (d) Average disruption of the physician's normal work following being on call;
- (e) Urgency when a physician must return to site when on call;
- (f) Requirement to attend multiple sites;
- (g) The degree of rurality of call groups in rural areas.

In order to measure those factors, we recommend the Medical Services Division develop simple and easy to use zero dollar fee codes that identify physician services provided while on call. We also recommend that, while a review is taking place of a call group, physicians in the call group would be required to maintain a diary for one or two months to record more specific information about the telephone calls received and the work done while on call. The combination of the MSP data and the content of diaries should provide objective data to consider the actual burden of call experienced.

We recommend that once the MSP fee codes are established the Medical Services Division be asked to introduce those fee codes as soon as possible.

Once the objective data describing burden are collected they can be used with a points based system to translate burden into MOCAP level. We have developed the following Matrix that we believe will properly identify a points total to be used in determining the degree of burden. We

have assumed the total number of points will result in the parties continuing to utilize the current MOCAP levels and values.

Points allocation proposal for MOCAP

<u>Factors defining burden of call availability</u>	<u>Points</u>	
Average frequency of MOCAP related telephone calls between 0700 and 1800	Low number of calls	0 points
	Medium number of calls	x points
	High number of calls	y points
Average frequency of MOCAP related telephone calls between 1801 and 2400	Low number of calls	0 points
	Medium number of calls	x points
	High number of calls	y points
Average frequency of MOCAP related telephone calls between 0001 and 0659	Low number of calls	0 points
	Medium number of calls	x points
	High number of calls	y points
Average frequency of facility visits where travel is required between 0700 and 1800 (source MSP code - only facility visits within the call period for new and unassigned patients are counted. Facility is defined as any location where the service is provided but does not include home.)	Low number of visits	0 points
	Medium number of visits	x points
	High number of visits	y points
Average frequency of facility visits where travel is required between 1801 and 2400 (source MSP code - only facility visits within the call period for new and unassigned patients are counted. Facility is defined as any location where the service is provided but does not include home.)	Low number of visits	0 points
	Medium number of visits	x points
	High number of visits	y points
Average frequency of facility visits where travel is required between 0001 and 0659 (source MSP code - only facility visits within the call period for new and unassigned patients are counted. Facility is defined as any location where the service is provided but does not include home.)	Low number of visits	0 points
	Medium number of visits	x points
	High number of visits	y points
Average time spent dealing with MOCAP related work between 0001 and 0659 (source MSP code or diary - intended to compensate the burden of time spent dealing with MOCAP related work at night where the work does not necessarily attract additional fees or require a facility visit)	No time spent	0 points
	Low time spent	x points
	Medium time spent	y points
	High time spent	z points

Factors defining burden of call availability		Points
Average post-call disruption - number of office billings during following 24h (source MSP code - fees from location where call provided are not counted. Fees from other locations are counted)	Low impact - high number of fees collected or low percentage reduction in fees collected. Medium impact - medium number of fees collected or medium percentage reduction in fees collected. High impact - low number of fees collected or high percentage reduction in fees collected.	0 points x points y points
Usual urgency of return to facility (source diary - most frequent clinically necessary time to return to facility)	Within call period	0 points
	Within 2 hours	x points
	Within 30 min	y points
Required to attend multiple sites (source contract)	No	0 points
	Yes	x points
Call group required to attend a rural location defined in the Rural Subsidiary Agreement (source contract)	No	0 points
	'C' community	x points
	'B' community	y points
	'A' community	z points
Specialty usually dealing with high acuity or complex patients (source pre-defined agreed specialty list)	No	0 points
	Yes	x points

- All physicians required to provide on-call availability under MOCAP are eligible for the basic availability payment of \$70,000 per call-group per annum
- Where data collection from MSP billings (including new codes to define MOCAP related events and their times), and intermittent call logs collected from ERPs and on-call physicians, identifies additional burden points physicians may be paid at band 2 or 1 according to the points achieved.
- For each factor describing burden points are assigned according to low, medium or high categories.
- Band 2 payment is \$165,000 per call group per annum. The threshold points required to achieve this band need to be defined.
- Band 1 payment is \$225,000 per call group per annum. The threshold points required to achieve this band need to be defined.
- Where a call group is required by contract to be on-site for provision of on-call availability the group is eligible for the band 0 payment of \$325,000 per annum

Once the monitoring Data have been available for what is considered to be a statistically significant period of four to five months, we recommend a technical and clinical committee, is set up to select certain call groups to be tested to determine the significance of the frequency of each event and to allocate the points that should be made available for each factor.

The technical and clinical committee may conclude that the number of payment levels should be more than the number of levels currently being utilized due to the data demonstrating more natural break points in the levels or that other changes to the points system and even considerations beyond the points system may be needed to ensure a fair and effective process.

The technical and clinical committee would then provide a full report to the Provincial MOCAP Review Committee who could then determine the process of implementing the new system of determining levels of payment for MOCAP.

We are satisfied that this careful approach should result in valid data being collected and the matrix being finalized in a meaningful way. We believe affected physicians will approach the data collection process responsibly and the combination of MSP and other collected data will be reliable. We would also observe that the collected data will naturally have the effect of recognizing difference in the burden of call between teaching hospitals and other hospitals.

This panel believes the model outlined above will achieve the objectives given to the panel. However, the technical and clinical committee, in reviewing the data, may reach a different conclusion. In such a case, the Physician Services Committee will have to decide on next steps.

5. MOCAP Budgets and Consultation

We consider it to be essential that MOCAP budgets and values be prepared and maintained on an open and transparent basis. We therefore recommend that:

- (a) Each Health Authority will determine the call groups that should exist within its MOCAP budget and, based on the procedures recommended in our Report, determine the levels of payment for the call groups in the Health Authority. The levels of payment for call groups will not change unless there has been a review conducted under our recommendations. This will form the basis of the Health Authority's annual distribution plan for MOCAP.
- (b) The annual distribution plan for MOCAP in each Health Authority will be reviewed with the MOCAP Contract Review Committee comprising representatives of the Health Authority, medical advisory committee, physicians receiving MOCAP and emergency medicine physicians in the Health Authority.
- (c) Each Health Authority will then review this distribution plan with the Ministry through the Provincial MOCAP Review Committee which will determine if the relative allocation of MOCAP funding to each Health Authority is appropriate within the Provincial budget for MOCAP.
- (d) Each Health Authority will then finalize its annual budget distribution plan for MOCAP. Any physician or physician group may challenge a Health Authority's distribution plan for MOCAP with the Health Authority under the Dispute Resolution Process recommended in this Report.
- (e) It is imperative that the time frame to complete this process is limited so that necessary decisions are not delayed.

We also recommend that section 17.3 of the Physician Master Agreement be revised in a manner that retains sections (a) and (b) relating to the MOCAP Objectives and criteria and that the balance of section 17.3 be revised to reflect the above.

6. Exceptions

We have been impressed with the number of different circumstances that can arise in the course of determining call groups. We also considered initially that special arrangements may be required for rural circumstances.

We have, however, decided to recommend that one MOCAP system be maintained with the ability to deal with unique circumstances in limited circumstances.

We recommend that, if a Health Authority can demonstrate to the Provincial MOCAP Review Committee it is necessary to maintain a particular call group where the call group will not satisfy all of the criteria to receive appropriate MOCAP compensation, they may seek agreement that an exception may be created for the call group. This process would prevent a number of exceptional arrangements being made at the local level and ensure a provincially consistent approach. The consideration of exceptions will not involve disputes which arise under the dispute resolution process. The Committee would only be reviewing the issue of providing a necessary service where the point allocations do not justify the level of MOCAP on a normal basis.

7. Call Back Arrangements

We heard a great deal about the difficulties experienced in the current call back arrangements. We have decided not to recommend any change in the call-back arrangements, except that the budget for call-back payments should be separated administratively from the MOCAP Budget and, if the amount of call-back exceeds a certain level it should trigger a review to determine whether the group should be provided with an on-call agreement. We make this last recommendation to ensure that a group of physicians does not receive more payments from call-back when they do not have an obligation to be available, as compared to physicians who must agree to be available to receive a lesser payment.

8. Dispute Resolution

Many of the representatives of specialists and Health Authorities were of the view that if the consultation process was robust and if objective data were used to decide call payments, there would be fewer disputes arising. We share that view.

At the same time, it is clear that disputes have existed under MOCAP and have been difficult to resolve. We have reviewed the Memorandum of Agreement made on 23rd July, 2010 dealing with the resolution of disputes which arose under the MOCAP distribution and distribution dispute resolution process described in the Articles 18.3 and 22.3 of the 2007 Physician Master Agreement.

In that Memorandum of Agreement, Articles 18.3(c) to (m) and Article 23.3(a) to (f) were suspended for the two years 2010-2012. This suspension has been continued until fiscal year 2014/15 (Article 17.3(c)).

It has been explained to us that the BCMA considered the MOCAP distribution dispute process established in 2007 was not workable due to the limitation that all disputes had to be decided within the Health Authority MOCAP Budget.

We have been specifically requested to determine how to resolve disputes which may arise in the future under MOCAP.

In the result, we recommend that physicians and Health Authorities have access to binding adjudication:

- (a) Any such dispute should be discussed with a view to resolution between the physician group, and the Health Authority MOCAP Contract Review Committee.
- (b) If the dispute is not resolved it may be referred to the Provincial MOCAP Review Committee for binding adjudication.
- (c) The Provincial MOCAP Review Committee in examining all disputes must determine only:
 - (i) whether the process of establishing the call group, and establishing the nature of call were consistent with the MOCAP principles and the applicable provisions of the PMA as amended by our recommendations, and
 - (ii) whether the total points allocated for a call group was established on a correct interpretation of the data available for MSP codes and physician diaries.

The jurisdiction of the Committee will be restricted to the issues identified above in (c). The Committee will not be entitled to disturb a final decision of a Health Authority that certain physicians do not need to provide on-call services under MOCAP unless the principles are breached as in c(i) above . At the same time, we consider the Committee should not be prevented from reaching a conclusion that may have financial consequences to the Health Authority. Such financial consequences will be effective in the subsequent fiscal year but will, at the discretion of the Provincial MOCAP Review Committee, generally have a retroactive effect at that time back to the date of the adjudication.

The Committee will establish its own procedures for the conduct of an adjudication.

We also recommend article 22.3 of the Physician Master Agreement be amended to reflect this Report.

9. Evaluation

If our recommendations are accepted and implemented we recommend a full evaluation of the results should be commenced at the end of the second full fiscal year after the recommendations were implemented under the direction of the Provincial MOCAP Review Committee.

We have now had over eleven years of experience with MOCAP and our recommendations are intended to respond to that experience. With the continuing changes in the care of patients and in new technology, we consider it advisable to determine whether our recommendations resulted in MOCAP responding flexibly to changed circumstances.

10. Concluding Remarks

We are providing our recommendations in compliance with the direction given to us under Article 17.4 of the Physician Master Agreement. We stand ready to provide any clarification of our recommendations as the Physicians Services Committee may require.

We have assumed that if our recommendations are accepted, the Physicians Services Committee would be responsible for amending the Physician Master Agreement and Appendix G of the Agreement which provides for a Template of the form of Agreements which are utilized under the Program.

Appendix 1

Excerpt from *2012 Physician Master Agreement (April 1, 2012)*

17.4 MOCAP Redesign

- (a) The Government and the BCMA shall create a panel (the "MOCAP Redesign Panel") to redesign MOCAP, in accordance with the provisions of this section 17.4.
- (b) The MOCAP Redesign Panel will be composed of five members, two of whom will be appointed by the Government, two of whom will be appointed by the BCMA, and Eric Harris, QC who shall serve as chair. The Government appointees and the BCMA appointees will have experience and expertise in the healthcare system.
- (c) The MOCAP Redesign Panel will commence its work by September 1, 2012, and will prepare a written report and recommendations for the redesign of MOCAP. In preparing that report and recommendations, the MOCAP Redesign Panel will, among other things, consider the following:
 - (i) compensation for on site on call availability that is different in structure and/or amount from compensation for off site on call availability;
 - (ii) a single base compensation rate for all off site on call availability;
 - (iii) in addition to the single base compensation rate referred to in section 17.4(c)(ii), additional compensation based on factors including but not limited to:
 - (A) the extent to which being on call disrupts the physician's personal and/or professional life including the number of calls the physician receives and/or the nature of the work arising when the physician is called; and
 - (B) the particular challenges associated with rural practice;
 - (iv) the requirement that response times will always be determined by patient clinical needs;
 - (v) administrative, reporting and billing rules required to ensure adequate data collection and ongoing review and assessment of the redesigned MOCAP; and
 - (vi) the funding constraints reflected by the Health Authorities' annual MOCAP allocations.
- (d) The written report and recommendations of the MOCAP Redesign Panel must:

- (i) address the resolution of disputes between physicians and Health Authorities over the distribution of MOCAP funds;
 - (ii) distinguish between issues relating to a physician's obligation to provide on call coverage and issues relating to payment for providing on call availability; and
 - (iii) ensure physician input into the Health Authorities' MOCAP funding distribution decisions.
- (e) By March 31, 2013, or such later date as may be agreed upon by the Physician Services Committee, the MOCAP Redesign Panel will conclude its work and will present its written report and recommendations for the redesign of MOCAP to the Physician Services Committee. The report and recommendations will be endorsed unanimously by all members of the MOCAP Redesign Panel or, failing unanimity, will reflect the views of the majority of the members of the MOCAP Redesign Panel.
- (f) The Physician Services Committee will have until May 31, 2013, or such later date as may be agreed upon by the Physician Services Committee, to accept by consensus decision the recommendations of the MOCAP Redesign Panel.
- (g) If the Physician Services Committee accepts the recommendations of the MOCAP Redesign Panel:
- (i) the Government, the Health Authorities and the BCMA will jointly develop a plan for the implementation of the redesigned MOCAP that will ensure the continued delivery of required services, which shall include the continuation of existing MOCAP Contracts until October 1, 2013;
 - (ii) this Agreement will be amended as required to implement the redesigned MOCAP;
 - (iii) the redesigned MOCAP will take effect on October 1, 2013; and
 - (iv) during and following the implementation of the redesigned MOCAP, the Government, the Health Authorities and the BCMA will closely monitor the performance of the redesigned MOCAP and will ensure that any unintended consequences are mitigated.
- (h) If the Physician Services Committee does not accept the recommendations of the MOCAP Redesign Panel then the MOCAP as described in sections 17.1, 17.2, 17.3, Appendix G, and Schedules and 2 to Appendix G will continue in force.

Appendix 2

Excerpt from *Medical On-Call/Availability Program (MOCAP) – Report of MOCAP Review Team (January 15, 2007)*

4. Recommendations:

The MRT recognizes that the HA's are ultimately responsible for managing within their individual MOCAP budgets, including providing best patient care by appropriately ensuring physician availability under MOCAP. The MRT also recognizes that the MOCAP Advisory Committee has responsibility for providing province-wide recommendations on the application of MOCAP. The following MRT recommendations have been made with those two understandings in mind:

4.1 Each physician on a MOCAP contact should have individually signed, and be specifically identified in, the call group contract.

4.2 HA's should administer MOCAP utilizing technology that is common to all HA's.

4.3 HA's should ensure that MOCAP is provided to compensate physicians only for their availability for emergent care for new or unassigned patients.

4.4 The BCMA and the Ministry should issue a joint communication to all physicians and HA's to clarify the contractually specified purposes of MOCAP.

4.5 Call groups should continue to be ideally comprised of a minimum of 3 physicians. Where a group is currently less than 5, and especially if less than 3 physicians, every effort should be made for recruitment where practical. The MRT recognizes that, in some areas of the province, full recruitment to obtain an ideally sufficient call group size may not always be possible. Those situations must be addressed individually and include contingency provisions for sustainable call coverage in a manner that respects physician well being and patient safety.

4.6 In solo and two physician communities or groups, there should never be the requirement to take continuous call as part of a MOCAP contract.

4.7 HA's should seek internal expertise through their Medical Advisory Committees, department heads, physician leaders, and other medical personnel to obtain best advice as to which call groups are absolutely necessary; which call groups might reasonably be combined; and which call groups may reasonably be reduced in Level. The MRT recognizes that HA decisions may not be identical to the advice received from any one source; the information exchanged constitutes advice, not direction.

4.8 HA's should examine MOCAP payments to ensure that MOCAP is not being paid if a physician or call group is already paid to be on site, on shift, or through another arrangement.

4.9 HA's should examine whether or not more than one call group or Level of call group is required for a given specialty or type of work within close geographic proximity, including within any one hospital; within any one HA at two or more different hospitals; or at two or more hospitals close to the common border in two different HA's.

4.10 HA's should undertake regular review to assess the efficiency and effectiveness of MOCAP in meeting patient needs and improving physician work life. This review may include assessment of the frequency that call group members are called in, or called to provide advice by telephone.

4.11 HA's should assess instances where physicians are performing more than one in three call, particularly if involved in multiple call groups, in order to achieve a measure of balance in physician work life, and support the health of physicians.

4.12 The MOCAP Advisory Committee should develop provincial criteria for determining the clinical need for call groups and their levels, including on-site call groups. Input from Medical Advisory Committees, clinical department heads, physician leaders, and other key medical personnel should be sought in the development of provincial criteria.

4.13 The MOCAP Advisory Committee should review the need for any modifications to the HA specific budget allocations within the negotiated total budget, currently set at \$126.4 million annually until 2012.