

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

1. Overview:

Article 5.3 of the 2006 Agreement provides for the MOCAP Review Team (MRT) to deliver a Report to the Government, the British Columbia Medical Association (BCMA) and the Health Authorities (HA's) by December 31, 2006, as the basis for changes or modifications, new mechanisms and/or allocations within the existing MOCAP budget.

As further specified in Article 5.3, the MOCAP budget will be maintained at the current level of \$126.4 million annually, and any changes to the MOCAP provisions of the 2004 Working Agreement will require the agreement of the Government and the BCMA.

This fixed budget exists within a context in which expenditures in 2006/7 will be close to \$130 million as HA's use the surplus from previous years due to under expenditure. In the next several years, the legitimate need for new MOCAP call groups will put an estimated pressure of 10% on the MOCAP budget, when the allocation as negotiated is fixed.

This Report of the MRT to the Government, the BCMA, and the HA's will address priority issues.

2. Background:

MOCAP began April 1, 2002, as established by the 2001 Working Agreement between the BCMA and the Government. This Agreement established an initial budget of \$125 million for MOCAP and a budget of \$2 million for Doctor of the Day (DoD). It also specified that payments would be "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". Call rates and levels were established in that Agreement.

Government subsequently created the MOCAP Policy Framework for HA's (last revised July 6, 2004), which provided additional specifications and guidelines for HA's and physicians with regard to MOCAP use. Government also created the MOCAP Advisory Committee, composed of HA and government representatives, which meets regularly to manage and oversee the program.

The 2004 Working Agreement confirmed MOCAP's purpose and structure as originally established in the 2001 Agreement effective to March 31, 2007, and combined the DoD budget with the MOCAP budget. The 2006 Agreement established the tripartite Review Team, the MRT, to conduct a MOCAP review

including identifying problems, recommending 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. The 2006 Agreement capped the MOCAP budget at \$126.4 million until 2012.

The MRT Terms of Reference and MRT Scope of Review are appended to this Report. All members of the MRT have been active participants in the meetings, and in the drafting of this report.

The MRT has reviewed three reports provided by government on various aspects of MOCAP: the Ministry Knowledge Management and Technology Division (KMT) report, *MOCAP Impact on After-Hours Medical Services (February 9, 2006)*; the eNRG Research Group report, *MOCAP Program Evaluation (January 2006)*; and, the Office of the Comptroller General (OCG) report, *Summary (fieldwork completed November 2005)*. Each report provided useful insights and set priorities for future action. In addition, the MRT has performed a preliminary review of detailed information on the more than 850 call groups in the HA's.

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.

3. Established Principles of MOCAP:

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 HA's 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 HA's require some flexibility in MOCAP administration due to variations in size and role of facilities within different HA's. However, decisions on MOCAP must be applied consistently, reflecting a similar rationale in all HA's.

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.

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.

5. Future Considerations:

The MRT has worked within a very constricted time frame in order to provide this Report. As well, the work of the MRT has been constrained by the Agreements which have fixed the terms and conditions under which MOCAP is paid, and fixed the total budget allotted to MOCAP.

Under the terms of the 2006 agreement, the MRT will produce its second and final report by December 31, 2009.

6. Appendices:

6.1 MRT Terms of Reference

6.2 MRT Scope of Review

Appendix 6.1 MRT Terms of Reference

Authority: Pursuant to the 2006 Agreement signed by the government of British Columbia, the British Columbia Medical Association (BCMA), and the Medical Services Commission (MSC), the parties will create a Medical On-Call/Availability Program (MOCAP) Review Team.

1.0 RESPONSIBILITIES

- To evaluate the impact of MOCAP on patient care, physician work life and other health professionals;
- To recommend solutions, mechanisms and/or alternatives (including redistribution or reallocation of MOCAP/Doctor of the Day funding) to effect greater patient access to time emergent care, to address inequities in MOCAP implementation, to increase value to patients and the public within the MOCAP budget allocation;
- To establish indicators to monitor and track MOCAP performance and set out evaluation criteria;
- To deliver a report to by December 31, 2006, as the basis for potential:
 - changes or modifications,
 - new mechanisms for scheduling and reporting, and/or
 - allocations to Health Authorities and call group levels within the existing MOCAP budget; and
- To conduct an evaluation of the changes implemented pursuant to above and recommend appropriate further revisions to the MOCAP by April 1, 2009.

2.0 STRUCTURE

- 2.1 Members:** There will be nine (9) members on the committee; three (3) appointed by government, three (3) appointed by the BCMA, three (3) appointed by the health authorities.
- Each party has the authority to change its representatives.
- 2.2 Alternates:** Alternate members may attend with prior notification.
- 2.3 Chair:** The committee shall be co-chaired by one of the government members and one of the BCMA members. The co-chairs will chair meetings on an alternating basis.
- The co-chairs, in consultation with each other, will be responsible for calling the meetings, setting the agendas, and ensuring that timelines are met.

2.4 Ex Officio Members: The Assistant Deputy Minister, Medical Services Division with the Ministry of Health, and the CEO with the BCMA may attend as Ex Officio members.

2.5 Support staff: Support staff provided by the BCMA and the government may be regular attendees. The Agreement does not include financial support by government for BCMA staff.

2.6 Secretary: The Committee Secretary will be responsible for booking meeting space, distributing agendas, minutes and related information in a timely manner, taking minutes of the meetings and maintaining a workplan.

2.7 Expert Advice Content expert advice may be sought, and individuals invited to make presentations to the Team.

3.0 MEETINGS

3.1 Frequency: Regular meetings will be held as necessary. The co-chairs will set out a tentative meeting schedule in advance of the first meeting. Meetings may be held in person or by video/teleconference.

Sites for the meetings may alternate between Vancouver and Victoria, but may be changed with the agreement of the committee.

4.0 FUNDING

4.1 Member Expenses: The government agrees to reimburse the BCMA for its physician (other than employees of the parties) representatives' participation in the committee. BCMA physician representatives should complete the required expense form and send to the BCMA for processing. Financial support of working groups / subcommittees appointed by the Committee is subject to government approval.

5.0 REPORTING

5.1 Minutes: Minutes and notes to file will be recorded by the Committee Secretary and will be distributed in draft form to the Committee members within 5 days following any meeting.

The government and the BCMA will provide a Committee Secretary to take minutes on an alternating basis, consistent with the representative chairing the meeting.

5.2 Requirements: The Committee will report through its members to their respective parties.

The Committee will report its findings to the Government, the BCMA and the Health Authorities by December 31, 2006, which will serve as the basis for changes or modifications, new mechanisms and/or allocations within the existing MOCAP budget, in the event such are identified.

The Committee will recommend appropriate further revisions to the MOCAP based on an evaluation of the changes implemented above, if any, to the Government, the BCMA and the Health Authorities by April 1, 2009.

6.0 CONSENSUS The Committee will develop recommendations by consensus. Consensus is defined as a resolution of the committee passed by a majority of the members after a reasonable process to reach unanimous approval. The government and/or the BCMA must either express in writing their support of the resolution or do not object in writing to the resolution within 30 days.

7.0 CONFIDENTIALITY From time to time, Committee members may possess information or documentation of a confidential nature. Such information will not be disclosed to persons other than members of the committee or staff of the Ministry of Health without consultation in the committee.

8.0 EXCERPTS FROM THE 2006 AGREEMENT

Section 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.

6.2 MRT Scope of Review

The Medical On-Call / Availability Program (MOCAP) is a provincial program established by the 2001 Working Agreement between the British Columbia Medical Association (BCMA) and the Government of British Columbia. MOCAP began April 1, 2002.

Article 5.3 of the 2006 Agreement requires a tripartite review team to conduct a review of the MOCAP.

Scope of Review: The review is described in Section 5.3 (b) of the 2006 Agreement (see below). It is proposed that its scope be limited to the parameters established in the 2004 Working Agreement (Article 5). MOCAP has been operating for over four years and this experience will provide information for the review. Additional information is available from the Ministry review of MOCAP using a three-pronged process undertaken in the last year.

Issues: Each of the three parties may identify issues with respect to MOCAP to be addressed in the review. For example, the Ministry of Health has concerns about the sustainability of MOCAP in that its budget is capped at \$126.4 million annually and it is becoming over-subscribed.

Purpose of MOCAP: The review should consider the purpose of MOCAP which was established as follows (see Policy Framework):

- Meet the medical needs of new or unassigned patients requiring emergency care by providing continuous coverage, as determined by the health authority (HA), at acute care hospitals, Diagnostic and Treatment centers, and specified emergency treatment rooms
- Meet standards of care as a minimum requirement of response to emergency on-call;
- Ensure that physicians providing coverage as part of an established call rotation (or physician group) are compensated for being available to provide this service;
- Ensure on-call coverage under this program translates into a sustainable workload for participating physicians; and
- Address gaps in continuous, sustainable on-call coverage with innovative, workable solutions that are consistent with program requirements.

Principles: The review should consider the principles of MOCAP which were established as follows (see Policy Framework):

- Provide on-call / availability coverage that is responsive and sustainable.
- Provide a program that is consistent with the provincial policy framework.
- Establish one provincial program, which is delivered consistently as part of a regionally required call schedule.
- Establish a program that pays for services required and is provided through contractual arrangements between the health authorities and physicians.
- Establish a program that is transparent and accountable.

2006 Letter of Agreement Section 5.3 (b)**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 0;
- 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 0 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 (iv) or section (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.