MEDICAL ON-CALL / AVAILABILITY PROGRAM (MOCAP)

POLICY FRAMEWORK

FOR

HEALTH AUTHORITIES

Ministry of Health Services

Revised July 6, 2004

PREAMBLE Page: 1 of 2

STANDARD OF CARE Effective: 22 Jan 2003

Description

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. The term of MOCAP is April 1, 2002, to March 31, 2004, with implementation February 1, 2003.

Purpose

The purpose of MOCAP is to:

- 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

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

POLICY: Standard of Care:

Accepted professional standards of care govern the quality of patient services provided under this program.

The maximum response times for each level do not replace the standard of care.

ALL response times will be dictated by patient need.

There will be situations where a patient's clinical circumstances require a physician to respond more urgently than the response time set out for the on-call / availability level. For example: a physician in a Level 3 group may be required to respond on-site to see a patient within 30 minutes due to the patient's clinical circumstances, not respond at the 16 hours as stated in Level 3 coverage.

Monitoring and reporting of required physician response times will be done to ensure call groups are designated at the appropriate response time level.

Chapter 1 **DEFINITIONS**

Effective: 22 Jan 2003

Term	Definition
Acute Care Facilities	A general acute care hospital as designated under the Hospital Act [R.S.B.C. 1996 Ch. 200], including Diagnostic and Treatment Centers.
Alternative Payments	Methods of payment, other than Fee-For-Service (FFS), for physician services**.**
Alternative Payments Program (APP)	Alternative Payments Program: A Ministry program, administered from within the Medical and Pharmaceutical Services (MPS) that promotes, provides funding for, and offers payment options to agencies employing or contracting physician services.
BCMA	British Columbia Medical Association.
Call Schedule	A schedule outlining call/availability coverage to be provided by physicians participating in a physician call group under contract to a health authority (HA).
Contracts	All on-call/availability arrangements will be described in contracts between the HA and the physician call groups. See appendices for template contract.
Emergency Room Treatment Centres	Small emergency medical treatment centres located in remote areas where emergency treatment is provided according to ER standards of care. May not have diagnostic capabilities such as lab or x-ray.
GP Specialist	A General Practitioner (GP) possessing additional expertise. For example anaesthesia, obstetrics, surgery.
Locum	A physician with appropriate medical staff privileges (locum tenens) who substitutes on a temporary basis for another physician.
MOHS	Ministry of Health Services.
Physician Call Group	A group of physicians agreeing to provide call coverage, as designated by the HA, in accordance with the definitions of Level l, Level 2, Level 3, On-site On-call, and Call Back.
New or Unassigned Patient	A patient who is not a patient of any physician participating in the call group.
Specialist	A physician with postgraduate medical education who is certified by the Royal College of Physicians and Surgeons of Canada (RCPSC), or an accepted licensed equivalent.

Chapter 2 **AVAILABILITY LEVELS AND PAYMENT RATES** Page: 1 of 1

Section 1 Effective: 22 Jan 2003

POLICY

The *2001 Working Agreement* sets out the availability levels, maximum response times and payment rates. Levels are based on response times within which physician groups are required to respond, *except call back as defined below*. The different levels and payment rates are determined by the clinical status of the patient and the expected physician response times, indicating that the response of physicians in call groups will be achieved within the designated time frame or sooner, for the majority of the calls. Physicians are to meet clinical needs of patients by providing the standard of care required. The levels and corresponding payment rates are listed below:

AVAILABILITY LEVELS	PAYMENT RATES
Level 1 – Coverage designated by a HA to require availability by telephone within 10 minutes, and available to be on-site urgently but no later than within 45 minutes.	$225,000 per annum for 24/7/52 coverage.
Level 2 – Coverage designated by a HA to require availability by telephone within 15 minutes, and available to be on-site within 2 hours.	$165,000 per annum for 24/7/52 coverage.
Level 3 – Coverage designated by a HA to require availability by telephone within 15 minutes, and available to be on-site within 16 hours of receiving the call.	$70,000 per annum for 24/7/52 coverage.
On-Site On-Call – When a physician is designated by a HA to be available on-site – groups in this category predominantly include tertiary obstetrics, anesthesia and neonatology. Physicians on APP contracts cannot form a call group for on-site on-call payments if already funded for full coverage.	$325,000 per annum for 24/7/52 coverage.
Call Back – Where a physician is not on-call but is called in by the HA to provide a service.	$250 per call back to a maximum of $26,000 per annum.

GUIDELINES

When a physician call group contracts to be available, they are assuring availability of services to meet the needs of patients' clinical circumstances and response times within the timeframes specified. This may preclude physicians from some types of work while they are scheduled to be on-call/available.

POLICY

MOCAP replaces all existing on-call / availability payment arrangements.

GUIDELINES

Physicians participating in this program will be available to:

- Provide timely and appropriate care to patients;
- Provide advice to physicians and other health care providers;
- Consult and advise physician colleagues on potential transfer cases including those referred by BCBedline and be available to receive and take responsibility for such cases and provide repatriation of these cases; and
- Consult and advise physician colleagues on the transfer of patients who require an alternate level of care or care in an alternate location and be available to receive and/or take responsibility for such transfer cases.

It is important to note most physicians generally participate with others in sharing on-call responsibilities in order to provide coverage for their own patients in or out of hospital, and / or to meet their professional obligations they have accepted as physicians. The introduction of MOCAP is not designed to compensate or replace these arrangements or obligations.

In general, on-call / availability services that are required and approved by HAs are to be provided on a continuous basis (24/7/52), however in some circumstances HAs may decide to provide on-call / availability on a intermittent basis. These arrangements may be due to a lack of human resources or other exceptional circumstances and may be subject to regular review of the Advisory Committee.

Health authorities must regularly review the effectiveness of such arrangements as part of their annual service planning process and provide plans, where feasible, to establish sustainable arrangements.

POLICY

The Program is to be applied in a consistent manner across the Province as per this policy framework. Health authorities are responsible for managing MOCAP, with some degree of flexibility to meet the various needs of acute care facilities and the populations they serve.

GUIDELINES

The appendices identify the level for most on-call / availability services required by HAs. Health authorities may choose to contract for services at a lower level than the level identified in the appendices. If a lower level is identified, HAs must ensure quality of care is maintained.

Where a HA has a requirement, with supporting evidence based on patient care parameters, to demonstrate that the availability level required is higher than the response level set out in provincial policy, there is the flexibility to seek such approvals from the Advisory Committee prior to contracting for the service at a higher level.

Chapter 4	**COVERAGE**	Page:	1 of 3
Section 1	**Continuous Coverage**	Effective:	22 Jan 2003

POLICY

Continuous coverage means patient access to services is 24/7/52. The physician call group(s) and HA will jointly review all on-call / availability and level coverage on an annual basis to ensure continuous coverage is sustainable.

GUIDELINES

Access of care to the patients in the community is paramount and HA's must ensure appropriate levels of on-call / availability are designated.

Physicians who work a time block or shift and report for a specified predictable schedule would not generally be eligible for full MOCAP funding; however there may be some circumstances where a partial MOCAP payment is applicable: For example - Radiology, Pathology, Medical Health Officer, Emergency (ERP's), ICU, Anaesthesia, Hospitalists and other unique groups may be eligible for partial funding for after hours on-call / availability.

POLICY

A call group of three or more physicians are required to provide continuous and sustainable coverage. Such a group provides availability of services for patients and sufficient time off for physicians.

GUIDELINES

In all call groups, especially those call groups of three or four physicians, it is imperative that **all** group members are prepared to commit to providing continuous coverage during the period of the on-call / availability contract.

In order to protect the principle of sustainability, wherever possible a HA will incorporate coverage of small unsustainable call groups within a larger call group, who are capable of responding to a wider range of calls.

Under special circumstances a small call group with high clinical demands may require different arrangements and must be reviewed through the Advisory Committee. Locums may be used to fill the on-call / availability roster to provide continuous coverage.

HA's may decide to require a call group of two physicians to provide availability services one in three each, and to be prepared to transfer patients out one third of the time. Where a HA enters into agreement for intermittent coverage, the hospital's medical staff, the public and the administration are to be aware of the arrangements.

POLICY

When a HA contracts with a group of less than three physicians it will be on a temporary basis, subject to the HA Physician Supply Plan, to develop sustainable coverage, either by enlarging the group size through planned recruitment or by combining coverage across multiple sites.

All temporary arrangements must be referred to the Advisory Committee for approval. There may be certain circumstances where the call group may not be sustainable due to demographics, and/or geography and lack of human resources.

Health authorities will assess the advisability / sustainability of providing the service on a part time basis.

POLICY

5.1.0 Contract

A physician call group must have a contract with the HA, in accordance with the template (Appendix A), to be eligible for MOCAP reimbursement / payments.

5.1.1 Individual Eligibility

As per the *Working Agreement*, on-call / availability arrangements should be sustainable.

GUIDELINES

In order to allow physicians a reasonable quality of life, it is recommended on-call / availability schedules for physicians are designed to provide services for **1 in 3 on-call**.

5.1.2 Multiple Call Group

A single physician may provide coverage simultaneously for more than one approved call group, except call back. Physicians belonging to more than one call group can receive payment, on a daily basis for participating in ***only one group at a time***, including Doctor of the Day, calculated on the highest call level for that physicians' call group. Example: A Physician cannot be paid twice to be on-call / available at the same time for two call groups.

5.1.3 Emergency Room – GP

In facilities that provide emergency room services to the community, a HA may require a call group (GP) to provide coverage for the emergency department during operating hours on a call-in basis. These physicians are a practice group and provide a comprehensive program with their own patients and would be disrupted for emergency call of other patients.

GUIDELINES

General practitioner physicians, as part of the emergency room call group will include coverage of the emergency room, admission of any orphan patients, and surgical assistance in the rare circumstances where the patient's own GP is unavailable to assist.

5.1.4 Emergency Room – On-Site Physicians

In facilities where there is an emergency physician designated by the HA, who is shifted in the emergency department duty on-site, they are not eligible for MOCAP funding. Where hours after scheduled or shifted work do not provide the volume to require on-site ERP's, physicians may be eligible for MOCAP for those hours.

5.1.5 Other On-Site Physicians

In facilities where physicians are compensated by alternate funding arrangements such as APP contracts, and/or salary and are on-site in a shifted position and report for a specified predictable schedule, including available for emergency response, those physicians will NOT be eligible for MOCAP payments during those shifts already compensated.

5.1.6 GP Specialists

Where a GP has additional expertise and medical staff privileges, which reflect additional training, they may form part of a specialist call group to provide continuous, sustainable availability coverage.

5.1.7 Locums

Locums or temporary replacement physicians with medical staff privileges and appropriate credentials are eligible to receive MOCAP payments, in accordance with a call group designated by the HA.

5.1.8 Call Back

Physicians may NOT receive payments for call back if receiving funds for Level 1, 2, 3 or on-site.

5.1.9 Small Remote Emergency Treatment Rooms (ETR)

Small remote locations may require emergency medical care to be available and some physicians may be eligible for MOCAP payments (e.g. Gulf Islands, tourist destinations and other communities where itinerant populations are large enough to dictate the need for MOCAP funding). ETR's must meet ER standards of care. ETR's will be designated by agreement between the Health Authority and physician(s) and they must be submitted to the MOCAP Advisory Committee for approval.

BUDGET

The annual budget for the MOCAP is set and this program must operate within the allotted amount.

PAYMENT

Health authorities will have contracts with physician call groups to provide specified coverage, and will provide payment in accordance with the policies of MOCAP.

Payment will only be made for on-call / availability services provided.

Chapter 7	**ACCOUNTABILITY**	Page:	1 of 4
Section 1	**Advisory Committee**	Effective:	22 Jan 2003

POLICY

An Advisory Committee will monitor the implementation of MOCAP to ensure policies are followed and ensure consistency in application of the program across the Province. The committee is made up of nominees from the HAs and MOHS and is accountable to MOHS.

- The committee's responsibilities include, but are not limited to:
- Providing recommendations on MOCAP policies and implementation;
- Developing program accountability and evaluation criteria;
- Develop a mechanism to audit call groups on a random basis;
- Reviewing a call group's designation, upon request; and
- Reviewing and responding to information acquired through program monitoring and evaluation, including making recommendations regarding program modifications.

Where the MOCAP Advisory Committee approves exceptions, the exception requires close monitoring of response time and need over a three-six month trial period. Results will be reported to the Advisory Committee upon completion of the trial period.

POLICY

Health authorities will provide to MOHS reporting required by the BTAA, and all other statutory requirements to meet public accounts.

Reporting will require information to:

- Evaluate the MOCAP and provide data that will reflect the success of the program in meeting its overall goals;
- Provide data to plan more effectively and improve the program.

These reporting requirements will be further defined pending policy modification in the future.

The following reported will be required from the HA's:

A semi-annual financial statement:

- Required within forty-five (45) days of the semi-annual period end.

An annual financial summary:

- Required within forty-five (45) days of the fiscal period end.

Physicians, as part of their physician group, will report to the HA:

- Dates of shifts worked by each member of the group;
- Disbursement of funds to call group members on a quarterly basis (if call group receives total call funds);
- Other information as per the contract specifications.

POLICY

MOHS will be responsible for reviewing the financial statements and status reports from health authorities; and, providing a semi-annual monitoring report to the Advisory Committee and health authorities. The monitoring report will include a program budget statement and a compilation of the 'issues' HA's submitted in their status reports.

The Advisory Committee will:

- Review the semi-annual monitoring reports prepared by MOHS;
- Determine program accountability and evaluation criteria;
- Require and review reports about temporary arrangements; and
- Ensure a preliminary evaluation of MOCAP is completed no later than
- October 1, 2003. The evaluation will focus on the appropriate designation of call groups; determine if rural incentives have been created; status/improvement of continuous coverage; patient transfer patterns as a result of MOCAP; and other topics related to patient outcomes as determined by MOHS and the HAs.

POLICY

Health authorities receiving program funding will be expected to comply with the program policy framework. The MOHS may withhold funding to HA(s) that fail to comply with the program policy framework.

APPENDIX 1

Designated On-Site On-Call*

HEALTH AUTHORITY	FACILITY	SERVICE
PHSA	W&FHP Hospital	Obstetrics
VCHA	Vancouver General Hospital	Anaesthesia
VCHA	Vancouver General Hospital	Trauma
VCHA	St. Paul's Hospital	Anaesthesia
VCHA	St. Paul's Hospital	Obstetrics
FHA	Royal Columbian Hospital	Anaesthesia (Obs)
FHA	Royal Columbian Hospital	Obstetrics
FHA	Royal Columbian Hospital	Pediatrics
FHA	Surrey Memorial Hospital	Anaesthesia (Obs)
FHA	Surrey Memorial Hospital	Obstetrics
FHA	Surrey Memorial Hospital	Pediatrics
VIHA	Victoria General Hospital	Anaesthesia
VIHA	Victoria General Hospital	Obstetrics
VIHA	Victoria General Hospital	Pediatrics

**Will be reviewed once Alternative Payments Program (APP) determines and subject to final review.*

APPENDIX 2

Availability Level[1]

Anaesthesia	Level 1
Cardiology - Interventional	Level 1
Cardiovascular Surgery	Level 1
General Surgery	Level 1
GP Emergency - Unstaffed emergency departments ONLY	Level 1
Internal Medicine - where primary consultant	Level 1
Neurosurgery	Level 1
Obstetrics & Gynecology	Level 1
Pediatrics	Level 1
Radiology - Interventional (ie. plastics and stents)	Level 1
Radiology - computed tomography for emergency diagnosis (trauma, stroke)	Level 1
Thoracic Surgery	Level 1
Vascular Surgery	Level 1
Neurology – where supporting acute stroke program	Level 1
Endocrinology	Level 2
Gastroenterology	Level 2
GP Anesthetics & GP Surgery	Level 2
Hematology	Level 2
Laboratory (Diagnostics)	Level 2
Nephrology	Level 2
Neurology	Level 2
Ophthalmology	Level 2
Orthopedic ****	Level 2****
Otolaryngology	Level 2
Plastic Surgery	Level 2
Psychiatry - if attendance required for new emergency room patients	Level 2
Radiology – consultative / interpretive	Level 2
Urology	Level 2
Geriatrics	Level 3

[1] *Maximum availability category designated. Health authorities may implement at a lower level where there is a reduced requirement. Health authorities may bring requests to implement at a higher level to the Advisory Committee.*

**** *MOCAP Advisory Committee approval previously given for HAs to determine if Level 1 required in some circumstances and designate call groups.*

APPENDIX 3

Unique Circumstances[2]

Acute Stroke Program (sites approved by Advisory Committee)	Level 1
Cell Separator (Vancouver General)	Level 1
Critical Care Unit (sites approved by Advisory Committee)	Level 1
Nisga'a Health Authority - Treaty Agreement	Level 1
Retinal Surgery (Vancouver General)	Level 1
Neurospine Program (Vancouver General)	Level 1
Hyberbaric	Level 1
Infectious Diseases (Vancouver General, St. Paul's, Royal Jubilee)	Level 2
Oncology (BCCA)	Level 2
Palliative Care (Vancouver General, St. Paul's, FHA	Level 2
Sexual Assault (where care not covered by other services)	Level 2
Transplant (BCTS)	Level 2
Rehab at Provincial Referral Center (GFS)	Level 3
Dermatology (Vancouver General)	Level 3
Rheumatology (CH&R)	Level 3
Medical Health Officer (MHO) prorated for daytime hours	Level 3

[2] *Recognized unique circumstances for either a provincial program or where there is provision of highly specialized service at specific facilities.*

APPENDIX 4

Medical On-Call / Availability Program (MOCAP)
Criteria for Call-Back Compensation

Definition:
Call Back level funding under the Medical On-Call Availability Program (MOCAP) is designed to remunerate physicians for their responses to emergent requests consistent with the following criteria:

Clinical Criteria:
1. To attend a patient where the person's condition is either not being treated by a physician or has changed so that lack of an emergency response would adversely affect the patient's outcome.
2. Requests for callback should be able to be verified that the clinical need requires an emergent call-back and that no other suitable alternatives are available.

Administrative Criteria:
1. The patient must be seen in a HA facility or referred to a HA designated facility.
2. Only call-backs for new or unassigned patients are eligible for remuneration. A new or unassigned patient is one who is not a patient of any physician participating in the call-back group.
3. MOCAP is not meant to provide for availability or response to elective consultations requested by peers and colleagues even if the consulting physician responds during the evening or weekend. The ability to schedule a consultation according to both clinical judgement of need and balanced with one's other work commitments, such as office hours, is part of normal practice.

Qualified Applicants:
Members of physician groups designated by the Health Authority for callback compensation.

Rate:
1. Each Call Back will be paid at a rate of $250. Eligible physicians may bill FFS or third party billings as appropriate.
2. Callback is part of MOCAP and will be billed to the Health Authority.
3. Callback is payable for each separate call and physicians may be called back more than once during the 24 hours and may bill for each time they are called back. However, only one callback fee may be billed per callback, regardless of the number of patients seen on that occasion.

Funding/Service Maximums:
Call Back arrangements reflect a maximum of 2 Call Backs/week (26 per quarter/ 104 per year) with an annual maximum funding commitment of $26,000, **per Call Back Group** except in exceptional circumstances for pooled call groups, as approved by the MOCAP Advisory Committee.

A summary of utilization by Call Back Group will be prepared on a quarterly basis.