

**EVALUATION REPORT OF THE  
PROVINCIAL MEDICAL ON-CALL AVAILABILITY PROGRAM  
(MOCAP) REVIEW COMMITTEE**

**September 30, 2024**

The Provincial MOCAP Review Committee (the “Committee”) was charged with conducting an evaluation of the redesigned MOCAP.

An evaluation was recommended by the Committee in its Report to the parties dated December 5<sup>th</sup>, 2018 (the “2018 Report”). Section 17.7 of the 2022 Physician Master Agreement specifies the criteria the Committee must consider when conducting the evaluation.

The Committee retained a former member of the Committee to assist with the work and are now respectfully submitting its Evaluation Report to the parties.

SUBMITTED September 30, 2024

ON BEHALF OF THE DOCTORS OF BC

ON BEHALF OF THE GOVERNMENT OF BC



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Dr. Sam Bugis



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Dr. Chad Kim Sing



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Dr. Fred Kozak



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Kevin Brown

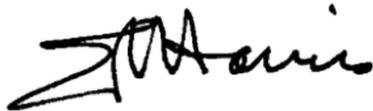
S. Vestvik

Dr. Sandra Vestvik



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Dr. Ralph Belle



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Eric J. Harris, K.C., Chair

## **MEDICAL ON-CALL AVAILABILITY PROGRAM And REDESIGN**

The Medical On-Call Availability Program (MOCAP) provides payments to physician groups for being available to meet the medical needs of new or unattached patients requiring emergency care.<sup>1</sup> MOCAP was first introduced as a \$125 million program in 2002. As is still the case today, MOCAP provides for availability at three Levels, as well as Doctor of the Day, Call Backs and a few On-site, On-call. These latter arrangements consume less than 1% of the budget. Only the three Levels were subject to the Redesign.

The MOCAP Redesign was recommended by the MOCAP Redesign Panel in its report to the Physicians Services Committee dated May 14th, 2013. The Committee was given the responsibility of bringing the Redesign to implementation. The Executive Summary of its 2018 Report gives this high-level description of the work and outcome, “After testing the model recommended by the MOCAP Redesign Panel...the Committee adopted a modified model as described in this Report. The modified model resulted in the MOCAP allocations as outlined in attachment D.” Attachment D is titled the “Allocation List” and indicates the Level at which all services should be placed.<sup>2</sup>

Prior to the Redesign, Levels 1 to 3 were allocated based on the urgency of response that might typically be required of a service. After the Redesign, the allocation changed to one based on the relative burden of being available.<sup>3</sup>

## **EVALUATION DESIGN**

The evaluation design stems directly from the four criteria embedded in Section 17.7 of the 2022 Physician Master Agreement:

### *17.7 Evaluation*

*The Government, the Doctors of BC, and the Chair of the PMRC will conduct an evaluation of the redesigned MOCAP through the PMRC in the fiscal year commencing April 1, 2023. Such evaluation will consider:*

*(a) whether the changes to MOCAP have improved or reduced the ability to determine call levels and whether the Final MOCAP Report is sufficiently clear in providing guidance for evaluating level assignments;<sup>4</sup>*

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<sup>1</sup> 2022 Physician Master Agreement, section 17.5(a).

<sup>2</sup> The Allocation List is on pages 21-22 of the 2018 Report. The Level of one service was TBD as described in Section 4 of the 2018 Report.

<sup>3</sup> 2022 Physician Master Agreement, section 17.5(d).

<sup>4</sup> Section 17.7(a) contains 2 of the 4 criteria grouped with an “and”.

- (b) the number of disagreements arising between Health Authorities and call groups and the reasons for those disagreements; and*
- (c) if there are further changes which should be made to MOCAP.*

## **EVIDENCE GATHERING**

Evidence to assess each of the criteria contained in section 17.7 was gathered from three sources: first through a comparative review of current call groups versus those that existed when data for the Redesign was first collected in 2016, second through a review of the Committee’s meeting minutes following the implementation of the redesigned MOCAP in 2019, and third through direct stakeholder input.

### **1. Call Group Comparison**

A comparison of call groups from 2015/16, the period in which the first data collection for the Redesign occurred, to 2024/25, the most recent fiscal year available was conducted to record the growth in call groups and determine if new services have appeared or if other changes to the Allocation List are required.

Over the 9-year period from 2015/16 to 2024/25 call groups increased by 13% (from 745 to 842). This amounts to approximately 1.4% growth in call groups per year on average.

A comparison of growth for each level from 2015/16 to 2024/25, after adjusting for the Redesign’s changes to levels, shows growth for Level 1 of 11% (from 446 to 493), Level 2 of 18% (from 229 to 270) and Level 3 of 13% (from 70 to 79).

A comparison of growth by Health Authority over the 9-year period reveals that FHA has had the highest growth at 20% followed by VIHA at 17% and NHA at 14%. PHSA has had the lowest growth at 8%, followed by both PHC and VCHA at 9% and IHA at 11%.

A comparison of call group names and descriptors in the 2024/25 data reveals 27 groups listed as “Maternity”, “Maternity Care” or “Maternity – FB OB”. These groups appear to be made up of Family Physicians who provide for the needs of unattached maternity patients and therefore justify a new entry in the Allocation List called “Maternity”.

### **2. Minute Review**

The minutes of the meetings of the Committee since the implementation of the redesigned MOCAP were identified as another potential source of data for the evaluation.

Disagreements between Health Authorities and call groups referred to the Committee would appear in the minutes. Likewise, any changes to the Allocation List sanctioned by the Committee since the Redesign implementation would also appear in the minutes.

The Committee met 23 times since the implementation of the redesigned MOCAP on April 1, 2019, until the date of this Report. The Committee met 7 times in the 2019, 6 times in 2020 and 10 times from 2021 to the date of this Report.

The first 11 meetings primarily dealt with call group appeals of their decreased placements within the redesigned MOCAP. Paragraph 3.6 of the 2018 Report says 67 groups decreased in level as the result of the Redesign. Most of these groups (62 of the 67) utilized the appeal process set out in the 2018 Report.

During the first year, many placement decisions were sustained, some with a re-evaluation to occur in 12 months. In other cases (e.g., Palliative, Plastics and Addictions), it was determined that additional data should be collected from the groups. Some groups (e.g., Palliative) were provided a delayed implementation date due to other circumstances and other services (i.e., Cardiac Surgery Assists and Surgical Assists) only recently had their placement decision determined.

At the May 19, 2019, Committee meeting a few additional appeals were brought forward but the Committee's response was the appeal window had closed for the year.<sup>5</sup>

In August of 2022 two new disputes were brought to the Committee not about level placement but concerning "Nature of Call".

In August of 2023 the Committee received an appeal about level placement from a group whose appeal of their decreased level in 2019 had been sustained.

Other than the 62 appeals submitted immediately prior to implementation from groups that were decreased through the Redesign (and some lingering unhappiness) there have been only 3 disagreements brought forward to the Committee.

### **3. Stakeholder Input**

It was important that input to the evaluation be sought from those affected by the Redesigned MOCAP: the Health Authorities and physician call groups. The Ministry identified 32 individuals across the Health Authorities whose roles involved the

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<sup>5</sup> January 14, 2019 was specified as the deadline for appeal applications as per Section 5 of the 2018 Report.

administration or oversight of MOCAP. The Doctors of BC suggested the 44 Sections as the appropriate touch point to gather physician input.

A web-based questionnaire was designed to allow input to be collected from the stakeholders. The questions (see underlined question numbers below) came directly from the four criteria set out in section 17.7 of the Physician Master Agreement. Questions 1 and 2 cover the two criteria in 17.7(a). Question 3 is more specifically worded than question 4 but both relate to 17.7(c) and question 5 covers 17.7(b). The questionnaire had links to the 2018 Report and its Allocation List so that respondents could refresh themselves with the contents of the document.

Emails were prepared inviting input to the evaluation with a hyperlink to the questionnaires.<sup>6</sup> The invitations were emailed to the Section Heads from the Doctors of BC Professional Relations Department and to the Health Authority stakeholders from the PMRC Secretariat.

An initial email invitation was sent to stakeholders on July 15, 2024, and followed up with two subsequent reminders sent in subsequent weeks to encourage responses. The last day for providing input was noted as August 16, 2024.

The Section Heads were informed that the questions could be shared with their members so that a comprehensive Sectional response could be provided.

The overall response rate was 43% (33 of 76). The Sections response rate was 52% (23 of 44) and the Health Authorities was 31% (10 of 32). Four individuals responded from Northern Health and two from each of Provincial Health Services, Island Health and Fraser Health. Appendix A has a list of the Sections that responded.

Question 1 asked, “Have the changes to MOCAP, described in the 2018 Provincial MOCAP Review Committee Report, improved or reduced the ability to determine call levels?”

Responses were:

Improved	22	67%
Reduced	5	15%
Neither	6	18%

If “Reduced” was selected the following question was asked, “How have the changes to MOCAP reduced the ability to determine call levels?”

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<sup>6</sup> The wording of Question 5 required separate questionnaires for Health Authorities and Sections.

Ten responses (2 Health Authority and 8 Sections) were received to the follow-up question but none of the responses addressed the question. Some responses qualified they did not know, and one Section said they did not receive MOCAP.

Question 2 asked, “Is the 2018 Provincial MOCAP Review Committee Report's Allocation List sufficiently clear in providing guidance for determining level assignments?” Responses were:

Yes	22	67%
No	10	30%
NA	1	3%

If “No” was selected the following question was asked, “What changes should be made to the Allocation List to improve its clarity in providing guidance for determining level assignments?”

Ten responses (3 Health Authority and 7 Sections) were received to the follow-up question but only 3 responses (2 Health Authority and 1 Section) addressed the question. Two individuals from the same Health Authority said the rationale for level decisions should be provided and the Section of Hematology and Oncology said Oncology should be separated into its respective groups (medical, radiation, and paediatric).

Question 3 asked, “Are there any further changes which should be made to MOCAP to improve the ability to determine call levels?” The responses were:

No	15	45%
Yes	18	55%

If “Yes” was selected the following question was asked, “What further changes should be made to MOCAP to improve the ability to determine call levels?”

Eighteen responses (6 Health Authority and 12 Sections) responded to the follow-up question but only 8 responses (2 Health Authority and 6 Sections) addressed the question.

Three responses suggested process changes, e.g., “firm process around workload...understood by clinicians...not a burden to capture”, “more frequent data requests”, or “potential urgency of response...and gravity of problems...to deal with, not volume...” Two more suggested distinguishing when physicians are responsible for multiple sites. Three of the Sectional responses suggested special considerations for their section.

Question 4 asked, “Are there any other changes which should be made to MOCAP?” The responses were:

No	10	30%
Yes	23	70%

If “Yes” was selected the following question was asked, “What other changes should be made to MOCAP?”

Twenty-two responses (6 Health Authority and 16 Sections) responded to the follow-up question and most of the responses (5 Health Authority and 14 Sections) addressed the question.

Three Health Authority respondents suggested MOCAP funding increase. One suggested consideration of burden of disease and recognition of emerging services. Another suggested, “call burden should determine the number of physicians on call” and that, “MOCAP levels be uncoupled from workload” and “reflect patient clinical need and criticality.” Another said, “physicians have repeatedly expressed frustration that the on-call provider has not responded fast enough based on patient need” and therefore suggested, “guidance around how soon to assess the patient”.

Eight Sections suggested MOCAP rate increases. One Section suggested its services be expanded to other sites. Another suggested a new level be created for it between levels 1 and 2. Another suggested “adapt for parental leave issues” and that health authorities be responsible for MOCAP schedules or the funding of them. Another suggested MOCAP be for “being available” not for volume already compensated by FFS. Another suggested financial modifiers for groups covering larger regions. Another suggested, “MOCAP...for ALL call groups”.

Question 5 asked, “Are you aware if your [Health Authority/Section] has had disagreements about call levels with one or more [call groups/Health Authorities]?” The responses were:

No	19	58%
Yes	14	42%

If “Yes” was selected the following question was asked, “Can you please describe what call groups it was with and what the reasons for the disagreements were?”

Thirteen responses (6 Health Authority and 7 Sections) were received to the follow-up question but only 8 responses (4 Health Authority and 4 Sections) addressed the question.

Health authority reported level disagreements with call groups included Plastics in VIHA and FHA, Neurology in FHA and rural Radiology and rural Family Practice on Hornby Island in VIHA.

Sectional reported level disagreements with Health Authorities included Urology (at level 1) in Interior Health and Island Health, general Neurology at VGH and stroke (at level 1) at SMH. Hematology and Oncology reported disagreements for Leukemia Bone Marrow Transplant at VGH and Medical Oncology at PHSA. Radiology reported disagreements with all Health Authorities.

## **CONCLUSIONS**

After having reviewed the evidence from all three sources, the following conclusions can be made which tie back to the four considerations set out in section 17.7 of the Physician Master Agreement:

### **1. The changes to MOCAP improved the ability to determine call levels.**

The majority of stakeholders at 67% agreed the changes to MOCAP had improved the ability to determine call levels while only 15% of stakeholders thought the changes had reduced the ability to determine call levels and another 18% were neutral.

### **2. The Final MOCAP Report is sufficiently clear in providing guidance for evaluating level assignments.**

The majority of stakeholders at 67% agreed the 2018 Report's Allocation List was clear in providing guidance for determining levels while 30% said it wasn't clear and 3% did not answer.

### **3. There have been only three disagreements arising between Health Authorities and call groups since the initial appeals in 2019.**

The Committee minutes reveal that when the Redesign was implemented in 2019 the Committee received appeals from 62 groups which had been decreased. Some of these groups remain unhappy. However, since then there have been only three disagreements brought to the Committee. Two concerning Nature of Call were brought in 2022 and one about level placement in 2023.

### **4. There are further changes which should be made to MOCAP concerning the Allocation List.**

The Allocation List has served Health Authorities and call groups in determining Level placements for the past 10 years but at this point requires a few minor updates.

In June 2024, the Committee completed its outstanding task from the 2018 Report of determining the Level of Surgical Assists. Therefore, the Cardiac Surgical Assist and

Surgical Assists entries in the Allocation List have been cleaned up and combined under the Surgical Assists entry with an added note in the Detail column.

A new Maternity entry has been added to the Allocation List to reflect the existing groups of Family Physicians who provide care for unattached maternity patients.

The Committee considered the suggestion from the Section of Hematology and Oncology that Oncology be split out into its respective disciplines but decided the current entry with its note in the Detail column provided sufficient clarity.

The Committee also took this opportunity to make a few formatting updates to the Allocation List in providing only one Level per entry. Examples of this formatting approach already existed in the Allocation List where exceptions are noted in the Detail column. This update provides consistency to the table without sacrificing any of its guidance in determining Level placements.

The updated Allocation List is in Appendix B.

Stakeholders suggested other changes to MOCAP in their responses to Questions 3 and 4 which are briefly touched on in the section above and including feedback which fell outside the scope of the evaluation parameters. The Committee has a complete list of all stakeholder input provided and recommends Government and Doctors of BC consider the comments and jointly determine what further action might be taken.

In summary, the Committee is pleased the Redesign of MOCAP, with its Allocation List, appears to have satisfied the original objectives of improving the ability to determine call levels while minimizing disagreements. Some of this success can be attributed to the Committee's stable membership and the able assistance of the Technical Committee.

## APPENDIX A: SECTIONS THAT PROVIDED INPUT<sup>7</sup>

Anesthesiology	Pediatrics
Emergency Medicine	PHPM
ENT	Psychiatry
Family Doctors	Radiation Oncology
Gastroenterology	Radiology
GI	Respiratory
Hematology & Oncology	Rheumatology
Infectious Diseases	Sports Medicine
Neurology	Surgical Assists
Nuclear Medicine	Urology
Orthopaedics	Vascular surgery
Palliative Medicine	

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<sup>7</sup> Section name as reported in the questionnaire.

## APPENDIX B: ALLOCATION LIST

Service	Level	Detail
Addictions Medicine	3	
Anaesthesia	1	<ul style="list-style-type: none"> <li>• Includes: General, 1<sup>st</sup> call, 2<sup>nd</sup> call and 3<sup>rd</sup> call, Cardiac and GP</li> <li>• Intraop Echo ,Transplant, Multi and Pain are level 2</li> </ul>
Cardiac Care Unit	1	
Cardiology	1	<ul style="list-style-type: none"> <li>• Includes General, Echocardiography and Interventional</li> <li>• Electrophysiology, including Pediatric, is level 3</li> </ul>
Cardiovascular Surgery	1	
Critical Care Unit	1	
Dermatology	2	<ul style="list-style-type: none"> <li>• Includes Pediatric Dermatology</li> </ul>
Emergency — GP	1	<ul style="list-style-type: none"> <li>• Includes Emergency — Pediatric</li> <li>• The following are level 2: Takla Landing, Hornby Island, Gabriola Island, Pender Island</li> </ul>
Endocrinology	2	<ul style="list-style-type: none"> <li>• Includes Pediatric Endocrinology</li> </ul>
Gastroenterology	2	
General Surgery	1	<ul style="list-style-type: none"> <li>• Includes Pediatric General Surgery</li> </ul>
Geriatrics	3	
Gynaecology	1	<ul style="list-style-type: none"> <li>• Includes Pediatric Gynaecology</li> </ul>
Hematology	2	<ul style="list-style-type: none"> <li>• PHSA Hematology is level 3</li> </ul>
Hospitalists	2	
Hyperbaric Unit	2	
ICU	1	<ul style="list-style-type: none"> <li>• Includes General, 1<sup>st</sup>, 2<sup>nd</sup> call and Pediatrics</li> </ul>
Infectious Diseases	2	
Internal Medicine	1	<ul style="list-style-type: none"> <li>• Includes General, 1<sup>st</sup> and 2<sup>nd</sup> call</li> </ul>
Lab Medicine	3	<ul style="list-style-type: none"> <li>• Includes, General, Anatomic, Biochemistry and Cardiopathology</li> <li>• Hematopath, Microbiology and Neuro pathology are level 2</li> </ul>
Maternal/Fetal Medicine	1	
Maternity	1	
Medical Genetics	3	
Medical Health Officers	3	
Neonatology	1	
Nephrology	2	<ul style="list-style-type: none"> <li>• Includes Pediatric Nephrology</li> </ul>
Neurology	2	<ul style="list-style-type: none"> <li>• Includes Pediatric Neurology and General Neurology (at sites where there is a stroke neurology group)</li> <li>• Neurology—stroke is level 1</li> </ul>
Neurosurgery	1	<ul style="list-style-type: none"> <li>• Includes Pediatric Neurosurgery</li> </ul>
Nuclear Medicine	3	
Obstetrics	1	<ul style="list-style-type: none"> <li>• Includes General, 2<sup>nd</sup> call and GP</li> </ul>
Oncology	3	<ul style="list-style-type: none"> <li>• Includes Medical, Radiation and Pediatrics</li> </ul>

Oncology – General Surgery	2	
Ophthalmology	2	• Includes General and Retinal
Orthopedics	1	• Includes Pediatric Orthopedics
Otolaryngology	2	
Palliative Care	3	
Pediatrics	1	• Includes General, CTU (blue/green), Biochemical Disease and Child Protection • ECLS/ECMO is level 2
Physical Medicine	3	
Plastic Surgery	2	• Includes Pediatric Plastic Surgery • The VGH Provincial Program is level 1
Psychiatry	2	• Includes Child, Forensic and Geriatric • Mental Health (GP/SP) is level 3
Radiology	2	• Includes General Radiology, CT/, US, KGH 2 <sup>nd</sup> call and MRI • Angiography, Interventional and the following are level 1: RCH, EKR, RIH, KGH, UHNBC, BCCH, SPH and NRH
Respiratory Medicine	2	• The following groups are level 1: BCCH, SPH and VGH
Retrieval	2	
Rheumatology	2	
Sexual Assault	2	
Surgery — GP	1	
Surgical Assist	1	• Includes Cardiac Surgery Assist
Thoracic Surgery	1	
Transplant	2	
Trauma	1	
Urology	2	• Includes Pediatric Urology
Vascular Surgery	1	