REPORT OF THE

PROVINCIAL MEDICAL ON-CALL AVAILABILITY PROGRAM

(MOCAP) REVIEW COMMITTEE

December 5, 2018

The Provincial MOCAP Review Committee (the "Committee") was charged with overseeing and guiding a redesign of MOCAP.

The Redesign was recommended by the MOCAP Redesign Panel in its report to the Physicians Services Committee dated May 14th, 2013. The Report of the Panel was accepted by the parties to the Physician Master Agreement (PMA) and amendments to Clause 17.4 of that Agreement specify the responsibilities of the Committee to bring the Redesign to implementation.

The Terms of Reference of the Committee (the "Terms of Reference") are attached as Attachment "A" to this Report. In summary, the Committee has had the responsibility to oversee and guide the implementation of the changes of MOCAP, to guide the implementation and transition to the new design and to determine the date of implementation.

The Committee was also charged with the responsibility to approve all changes to call groups until the date of implementation of the new design of MOCAP. During the course of the work of the Committee, the Committee approved a significant number of changes to call groups as well as the creation of new call groups. This process has been necessary to maintain the viability of MOCAP while the Committee did its work.

The Committee has now completed its work and are respectfully submitting its Report to the parties to guide implementation.

SUBMITTED December 5, 2018

ON BEHALF OF THE DOCTORS OF BC

Dr. Sam Bugis

Dr. Sean Ebert

Dr. Randy Moore

ON BEHALF OF THE GOVERNMENT OF BC*

Dr. Peter Blair

Rod Frechette

Dr. Malcolm Ogborn

Eric J. Harris, Q.C., Chair

*The Government appointees on the Committee also included Dr. Alan Meakes and Dr. Andy Webb who were replaced by Dr. Blair and Dr. Ogborn.

1. EXECUTIVE SUMMARY

1.1 The Committee has now completed its work with one exception as described in section 4.

1.2 After testing the model recommended by the MOCAP Redesign Panel, through the collection and analysis of data the Committee adopted a modified model as described in this Report.

1.3 The modified model resulted in the MOCAP allocations as outlined in attachment D.

1.4 These allocations are to be implemented subject to the review and implementation procedures outlined in sections 5 and 6.

1.5 The Committee has recommended an evaluation be conducted of the changes made to MOCAP through this Report.

2. WORK OF THE COMMITTEE

2.1 The Committee began its work in May of 2014.

2.2 The Committee, as provided for in the Terms of Reference, was supported by a technical and clinical committee to assist in data collection, points allocation and the determination of levels for the new design of MOCAP. The Members of the technical committee are:

Anita Bowker – Interior Health Authority
Astrid Levelt – Providence Health
Patrick Melia – Doctors of B.C.
Abigail Pittman – Ministry of Health

2.3 This Report is intended to continue and enhance the role of MOCAP to meet the needs of new or unassigned patients requiring emergency care by physicians in British Columbia.

2.4 The Report creates a new emphasis on the relative burden experienced by physicians providing MOCAP coverage as compared to the previous reliance on the urgency for being available.

2.5 The Committee, as instructed, considered the work done by the MOCAP Redesign Panel as stated at pages 21 to 23 of their Report:

> 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 recommended the Medical Services Division develop simple and easy to use zero dollar fee codes that identify physician services provided while on call. We also recommended 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

Factors defining burden of call availability		Points
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 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
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	0 points
	Medium impact – medium number of fees collected or medium percentage reduction in fees collected	X points
	High impact – low number of fees collected or high percentage reduction in fees collected	Y points
Usual urgency or return to facility (source diary – most frequently clinically necessary time to return to facility)	Within call period	O points
	Within 2 hours	X points
	Within 30 minutes	Y points
Required to attend multiple sites (Source contract)	No	O points
	Yes	X points
Call group required to attend a rural location defined in the Rural Subsidiary Agreement (Source contract)	No	O points
	"C" Community	X points
	"B" Community	Y points
	"A" Community	Z points
Speciality usually dealing with high acuity or complex patients (source pre-defined agreed specialty list)	No	0 points
	Yes	X points

2.6 It was determined that data should be collected to test the factors recommended by the MOCAP Redesign Panel.

2.7 An evaluation tool was developed which was intended to permit a transparent method of assigning call group levels based on the actual burden of call, including the impact on work life peri and post-call. The tool used zero value billing codes concurrent with location codes as follows:

- 96601 MOCAP call - Responds to phone/pager/other contact.
- 96602 MOCAP call - Responds to phone/pager/other contact and directly attends the new and unattached patient.

The tool also provided that patient information should be recorded in accordance with normal practices. The data would include the referring practitioner number, the facility

number to identify where the patient was located, and the MOCAP call number recorded in a sub-facility field.

2.8 A pilot test was developed and conducted with two test groups:

- Group A0001: St. Paul's General Surgery
- Group A0002: St. John E.R. Group (Vanderhoof)

The test period for Group A0001 was from November 20-24, 2014 and for Group A0002 from October 20-November 3, 2014.

2.9 A second pilot test was also conducted with two groups from each health authority.

2.10 The pilot tests provided useful information but did not, in the view of the Committee, disclose certain necessary information including:

(a) the average time taken to attend to emergency calls from midnight until 7:00 am;

(b) the average disruption of the physicians' normal work following being on call;

(c) the urgency for a physician who must return to the facility when on call;

(d) the requirement to attend multiple sites; and

(e) the degree of rurality of call groups for rural sites.

2.11 Based on the assessment of the results of the pilot tests, the Committee then moved forward to collect data from all physicians who work in a MOCAP call group. The Committee made certain modifications to the data that allowed the following to be calculated:

(a) to determine response times for any call requiring a patient attendance (in place of 2.10 (a) and (c)); and

(b) the time spent while attending a patient,

It was expected that the frequency of calls and the number of attendances would disclose the burden of care. It was considered that rurality and attendance at multiple sites could be determined from other data already available. There was no alternate measure for the impact of on call and the disruption on the physicians' normal work.

2.12 A communication plan was designed and implemented to collect the Provincial data. In total, 743 groups representing 3,402 physicians were eligible to participate in the data analysis of which 724 submitted data.

2.13 In the months of February and September, 2016, the data collection process took place. The second period of data collection was undertaken as certain call groups asserted that the February data collection did not properly demonstrate their typical call burden due to seasonality. Other call groups identified difficulties with communications and technology which made the data submitted to be wrong.

2.14 Over 57 call groups participated in the data collection in September, 2016. The Committee adopted the approach that, if a call group stated that the issue was seasonality, their data from the two collection periods would be averaged. If the issue identified was technical or communication issues, the September data would replace the February data.

2.15 The Technical Committee first ensured that all fields had been completed accurately and data had been submitted under the current call group. This involved significant follow-up to determine if the information was accurate and sufficient to provide an assessment of call burden.

2.16 The result of this analysis was that it was evident that some call groups had all physicians report data and some groups reported on behalf of only certain physicians in the call group. Attachment "B" provides a list of all call groups who did not participate at all as well as an explanation of why they did not respond if any explanation was received.

2.17 The number of records received was 159,869 (total 01s, and 02s), which is the sum of all raw records received, before any merging/replacing/correction/deletion of duplicates. The final data set included all regular Level 1, 2 and 3 MOCAP groups and excludes all Test and New groups. It also included reported "Z" codes (attached patients) for rural GP Emergency groups (see section 3.5 and 3.6 for discussion). The number of records is 144,225. The following table provides an overview of the number of records by type:

Types of records received in the data collections

Type of Record	Number	Percent of Total*
Calls (96601)	78,029	54.1%
Patient Visits (96602)	65,888	45.7%
Blank fee Code	308	0.2%
Total Claims (96601 & 96602)	143,917	99.8%
Manually entered records **	35,233	24.4%
Rural records*	34,463	23.9%
Dummy PHNs	617	0.4%

*The total number of records is 144,225

The number of records (96601 and 96602) reported within groups ranged from one to 2,395. The mean number of records per group was 190, and the median was 122. The tables below illustrate the range of records by group, as well as the mean and median, by type of record:

Descriptive statistics by type of record (all groups)

	Number of Records*			
Record Type	Min	Max	Mean	Median
96601 (all groups)	1	2,391	104	61
96602 (all groups)	1	1,382	92	51
Total (all groups)	1	2,395	190	122

*Excludes the 1,201 removed records from the total counts

Descriptive statistics by type of record (rural groups)

	Number of Records*			
Record Type	Min	Max	Mean	Median
96601 (rural groups)	1	724	73	43
96602 (rural groups)	1	759	107	43
Total (rural groups)	1	1,466	174.6	90

*Excludes the 1,201 removed records from the total counts

2.18 The Technical Committee used the Ministry of Health attachment algorithm to see which physicians included records for patients who were already attached to them.

The attachment algorithm determines a patient's attachment status by identifying the practice or practitioner who provided the majority of a patient's recent care. A patient is considered attached if the majority of their visits in the last year (5 or more) were made to the same independent/group practice. If the patient did not have at least five visits in the past year, the algorithm checks an additional five years to find five visits and uses the majority of those five.

If a patient does not have five visits but has three visits to the same practice, they are considered attached. If they do not have at least three visits, they are considered unknown. Practices are identified as groups of physicians billing under the same payee or Data Centre number.

Physicians in GP Emergency groups were advised to enter calls and visits for attached patients under a distinct code (Z-codes). In November 2016 the Committee agreed that all attached calls and Z-codes would be included in the analysis for rural groups. Physicians in rural GP Emergency groups act in a different role from regular practice when working in the ER; therefore, all attached patients from regular work are new patients in the ER. The table below provides a summary of the number of claims with attached patients that were included in the analysis:

Records with attached patients

Type	Number of Claims
Claim with attached patients	1,349
Claim with Z-code	6,772

2.19 The Technical Committee determined whether any data quality issues would effect the measurement of burden. It was found that data quality issues affected only a small proportion of the data. The Technical Committee determined options to mitigate data quality issues which were considered by the Committee.

2.20 The Committee then adopted metrics to allow calculation of:

(a) average frequency of MOCAP calls;

(b) average frequency of MOCAP visits where travel was required;

(c) usual frequency of return to facility;

(d) specialty usually dealing with high acuity or complex patients;

(e) call groups required to attend rural locations;

(f) call groups that provide coverage for multiple sites:

(g) percentage of calls requiring visit;

(h) coverage and calls outside of schedule.

3. MODEL DEVELOPMENT

3.1 The following assumptions guided the model development process:

(a) the current placement and distribution of on-call programs was likely reasonable for the most part;

(b) the determination of "cut-points" between the levels of call should become apparent from the data analysis;

(c) the model would recognize the additional impact on rural physicians while on call which could arise from limited availability of support resources; and

(d) the current three levels of call and their associated payment would be maintained to differentiate burden.

3.2 The model development involved assigning point values to each metric adopted. Boundaries were selected and tested to separate the three levels of call.

3.3 In most program areas, it was possible to determine an appropriate level for each call group following this approach. A number of groups however fell near the "cut-points" between levels. This prompted a very exhaustive determination of the characteristics of the call groups which fell near the cut-points.

3.4 Other call groups had very low call volumes which may result in health authorities examining the need for such call groups.

3.5 The result of all this analysis was the adoption of the point allocation matrix as attached as Attachment "C". The modifications made to this matrix from the initial matrix proposed by the MOCAP Design Panel are based upon the considerations described in this report.

3.6 Of the 743 groups at the time of the survey (724 participated and 19 did not participate), 610 have no change in level, 67 have a decrease in level and 66 have an increase in level. Attached as Attachment "D" is the listing of call services with their assigned levels. Broadly speaking, most of the call services are relatively unchanged but some of the groups within a service may increase or decrease. It is noted that six services will have a general decrease in the level. One service is dealt with under section 4.

3.7 This result has been made as objectively as possible. However, some judgment has been applied by the Committee. An acuity factor has been applied of high, medium or low to each service or discipline. This acuity factor exerts a significant influence on establishing MOCAP levels. This factor is a reflection of the opinion of the Committee, as to whether the specialty usually deals with extremely ill or complex patients.

3.8 While MOCAP was designed in principle for physicians providing direct patient care, it is evident that some specialities do not provide direct patient care but have a role with new or assigned patients which may not have been adequately reflected in the data collection process. The Committee applied its judgment on those issues.

3.9 With the change to the burden of call to determine the program level, the response times for all levels will require a response to a telephone call/pager within 10 minutes and attendance based on the patient need.

4. SURGICAL ASSISTS

4.1 The Committee is of the view that we need more data and information with respect to the burden of call on call groups which provide surgical assists, either in the context of a subspecialized surgical service (e.g., cardiac), or as a service to a broader range of surgical disciplines.

4.2 We have decided to not delay the release of our Report to resolve this issue, but to establish a process consistent with section 5 of this Report to allow us to reach a conclusion.

4.3 To be specific, the Committee must decide on the implementation of our Report whether those call groups will be set at Level 1 or Level 2.

4.4 We therefore direct that a review be conducted by requesting certain data or information which are intended to determine more precisely the current burden being experienced by these call groups.

4.5 We will contact the representatives of these groups following the issuance of our Report.

5. IMPLEMENTATION

5.1 The Implementation date for the redesigned MOCAP will be April 1, 2019.

5.2 It is essential that every Health Authority implement the results of this Report in order to maintain consistency. Any variation will be made only with the agreement of the Committee.

5.3 Should a call group disagree with the level allocated by the Committee such a disagreement will be brought to the Committee for review and decision. Any application to the Committee should be made after consultation between the Health Authority and the call group by January 14, 2019.

5.4 Should the disagreement arise from a speciality section as a whole such an application for review should also be made by January 14, 2019.

5.5 The Committee will provide an application form to ensure that the basis of disagreement is fully described.

5.6 The Committee will consider the written application and may meet with the applicants. It will render its decision on each application in writing.

6. REVIEW OF CALL LEVELS AFTER APRIL 1, 2019

6.1 If, after April 1, 2019, a Health Authority or call group consider that, based on the factors identified in the point allocation matrix, things have changed in a manner which should involve a review of the assigned level of call, such groups can bring an application to the Committee to initiate such a review.

6.2 The committee will determine its procedures to consider such applications.

6.3 The Committee recommends this process continues for the term of the new Physician Master Agreement.

7. EVALUATION

7.1 The Committee recommends that an evaluation of the results of the implementation of the redesigned MOCAP be conducted in the fiscal year commencing April 1, 2021. Such an evaluation should consider:

(a) whether the changes improved or reduced the ability to determine levels of call;

(b) the number of disagreements arising between Health Authorities and call groups, and the reasons why; and

(c) if there are further changes which should be made to MOCAP.

8. CONCLUDING REMARKS

It became apparent in the deliberations of the committee, that in some instances, MOCAP has been used by Health Authorities as a part of a strategy to sustain clinically important services, even though the model of care is outside the scope of MOCAP. Such care could involve a degree of availability to attached patients that could fairly be considered beyond the expectation of usual patient attachment, or could involve availability for services essential to patient care but not requiring patient attachment. The Committee felt that its mandate was to apply the principles of the program to all groups, recognizing that this would create challenges for groups where in the past it had been applied in the manner described above. The Committee feels that the future smooth operation of the MOCAP program requires that its application remains true to its principles and encourages vigorous and timely discussion and implementation of other models of remuneration where services not captured under the intent of MOCAP are not currently adequately supported.

Attachment A: Terms of Reference

Provincial MOCAP Review Committee Terms of Reference

(a) The Government and the Doctors of BC will create a committee (the "**Provincial MOCAP Review Committee**"). The Provincial MOCAP Review Committee shall be composed of three representatives appointed by the Government (including any representatives of Health Authorities) and three physician representatives appointed by the Doctors of BC. The Government and the Doctors of BC will select an independent Chair for the Provincial MOCAP Review Committee. If the parties are unable to agree on an independent Chair, either of them may request the Chief Justice of the Supreme Court of British Columbia make the appointment and the individual so appointed will be the Chair of the Provincial MOCAP Review Committee.

(b) The Provincial MOCAP Review Committee will make decisions by majority vote. In this case, a majority vote must consist of all of the representatives of either party and the Chair of the MOCAP Review Committee.

(c) The Provincial MOCAP Review Committee will have the following responsibilities during the transition to and implementation of the redesigned MOCAP program:

(i) overseeing and guiding the MOCAP redesign and implementation process as set out in the Report of the MOCAP Redesign Panel dated May 14, 2013 ("**MOCAP Report**") including:

(A) overseeing the work of a technical and clinical committee related to data collection, points allocation and the determination of payment levels for the redesigned MOCAP program in accordance with the MOCAP Report;

(B) providing either:

(1) final approval of the work of the technical and clinical committee, or

(2) a report to the PSC that the technical and clinical committee has been unable to achieve the objectives of the MOCAP Report. In such a case, the PSC will determine the next steps and clause 17.5 of the Physician Master Agreement will not apply.

(ii) a overseeing the transition to the redesigned MOCAP program in accordance with section (d);

(iii) determining the process for implementation including the implementation date for the redesigned MOCAP program.

(d) In order to assist in the orderly implementation of the MOCAP Report, the parties agree to the following:

(i) subject to section (d)(ii), current on-call arrangements will continue in effect until those arrangements are modified through the redesigned MOCAP program;

(ii) during the period necessary to implement the redesigned MOCAP program, only minimal changes to call groups will be made;

(iii) the Provincial MOCAP Review Committee will approve all changes to call groups during the transition period;

(iv) the Provincial MOCAP Review Committee will resolve any disputes between physicians and Health Authorities with respect to on-call arrangements during the transition period;

(v) once the new process is finalized on a continuous basis either a call group or Health Authority may provide notice to the other party of their wish to review the existing arrangements; and

(vi) any changes in the payment level for call groups arising from such a review will be effective after 90 days' written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.

Attachment B: Groups that did not participate in the 2016 data collections

Reasons provided for non-participation:

- majority did not provide an explanation
- physician(s) not available during data collection periods
- data submitted under wrong group
- data entered incorrectly
- data collection was too onerous

HA	Call Group #	Call Group Name	Level
IHA	B0003	OMH - GP - Surgery	2
IHA	B0011	EKH - Internal Medicine	1
IHA	B0020	GP - Surgery	2
IHA	B0049	RIH - Pathology	2
IHA	B0075	KGH - Radiology – 1st call	1
IHA	B0076	KGH - Radiology – 2nd call	2
IHA	B0083	LIH - GP - Anaesthesia	2
IHA	B0128	KBH – Plastic Surgery	2
NHA	C0064	FN Communities Response After Hours	3
NHA	C0069	Terrace Psychiatry	2
PHSA	D0096	Medical Oncology - PG	2
VCHA	E0050	General Surgery	2
VCHA	E0060	GP - Emergency	1
VCHA	E0063	GP - Emergency	1
VCHA	E0115	Neurology	3
VCHA	E0125	Ortho - Reconstructive	2
VCHA	E0126	Ortho - Trauma CASC	1
VCHA	E0169	Spine Program CASC	1
VCHA	E0183	Vascular Surgery	1

Attachment C: Modified Point Allocation Matrix

Average frequency of MOCAP related telephone calls between 0700 and 1800	No calls	0
	Low number of calls	1
	Medium number of calls	2
	High number of calls	3
Average frequency of MOCAP related telephone calls between 1801 and 2400	No calls	0
	Low number of calls	1
	Medium number of calls	2
	High number of calls	3
Average frequency of MOCAP related telephone calls between 0001 and 0659	No calls	0
	Low number of calls	2
	Medium number of calls	4
	High number of calls	6
Average frequency of facility visits where travel is required between 0700 and 1800	No visits	0
	Low number of visits	2
	Medium number of visits	4
	High number of visits	6
Average frequency of facility visits where travel is required between 1801 and 2400	No visits	0
	Low number of visits	2
	Medium number of visits	4
	High number of visits	6
Average frequency of MOCAP related telephone calls between 0001 and 0659	No visits	0
	Low number of visits	4
	Medium number of visits	8
	High number of visits	12
(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.)		
Usual urgency of return to facility - as measured by percent of calls that result in an attendance	No attendance	0
	Less than 1/3	2
	Between 1/3 and 2/3	4
	2/3 or more	6
Required to attend multiple sites (Source: contract)	No	0
	Yes	4

		Alternate Points Scenarios		
Call group attending a rural location defined in the Rural Subsidiary Agreement	No	0	0	0
	'C' community	10	10	20
	'B' community	15	15	30
	'A' community	20	20	40
Specialty usually dealing with high acuity or complex patients (Source: pre-defined agreed specialty list)	Low	20	20	10
	Mid	45	60	30
	High	70	100	50

Attachment D: Allocation List

Service	Level	Detail
Addictions Medicine	3	
Anaesthesia	1 2	• Includes: General, 1st call, 2nd call and 3rd call, Cardiac and GP • Intraop Echo ,Transplant, Multi and Pain are level 2
Cardiac Care Unit	1	
Cardiology	1	• Includes General, Echocardiography and Interventional • Electrophysiology, including Pediatric, is level 3
Cardiovascular Surgery	1	
Cardiac Surgery Assist	TBD	• Existing groups will stay at their current level until PMRC concludes its review (see Final Report section 4): FHA - Royal Columbia Hospital –Level 2 VCHA - St. Paul's Hospital – Level 1 VCHA - Vancouver General Hospital – Level 1 VIHA - Royal Jubilee Hospital – Level 1
Critical Care Unit	1	
Dermatology	2	• Includes Pediatric Dermatology
Emergency – GP	1 2	• Includes Emergency – Pediatric • The following groups are assigned level 2: NHA - Takla Landing – Emergency GP VIHA - Hornby Island – Emergency GP VIHA - Gabriola Island – Emergency GP VIHA - Pender Island – Emergency GP
Endocrinology	2	• Includes Pediatric Endocrinology
Gastroenterology	2	
General Surgery	1	• Includes Pediatric General Surgery
Geriatrics	3	
Gynaecology	1	• Includes Pediatric Gynaecology
Hematology	2	• The PHSA Hematology group is assigned level 3
Hospitalists	2	
Hyperbaric Unit	2	
ICU	1	• Includes General, 1st , 2nd call and Pediatrics
Infectious Diseases	2	
Internal Medicine	1	• Includes General, 1st and 2nd call
Lab Medicine	2 3	• Includes, Hematopath, Microbiology and Neuro pathology • General, Anatomic, Biochemistry and Cardiopathology are assigned level 3
Maternal/Fetal Medicine	1	
Medical Genetics	3	
Medical Health Officers	3	
Neonatology	1	
Nephrology	2	• Includes Pediatric Nephrology
Neurology – Stroke	1 2	• Neurology – stroke level 1 • Pediatric Neurology and General Neurology (at sites where there is a stroke neurology group) are assigned level 2
Neurosurgery	1	• Includes Pediatric Neurosurgery

Nuclear Medicine	3	
Obstetrics	1	• Includes General, 2nd call and GP
Oncology – General Surgery	2	
Oncology	3	• Includes Medical, Radiation and Pediatrics
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 has been assigned level 2
Physical Medicine	3	
Plastic Surgery	2 1	• Includes Pediatric Plastic Surgery • The Vancouver General Hospital Provincial Program call group has been assigned level 1
Psychiatry	2 3	• Includes Child, Forensic and Geriatric • Mental Health (GP/SP) has been assigned level 3
Radiology	1 2	• The following groups are assigned level 1: FHA - RCH – Radiology – Gen/CT/US IHA - EKR – Radiology IHA - RIH – Radiology IHA – KGH – Radiology 1st call NHA - UHNBC – Radiology PHSA - BCCH – Radiology VCHA - SPH – Radiology – CT/Body VIHA - NRH - Radiology • Level 1 includes Angiography and Interventional • General Radiology, CT/, US, KGH 2nd call and MRI assigned level 2
Respiratory Medicine	2	• The following groups are assigned level 1: PHSA - BCCH – Respiratory Medicine VCHA - SPH – Respiratory Medicine VCHA - VGH – Respiratory Medicine
Retrieval	2	
Rheumatology	2	
Sexual Assault	2	
Surgery – GP	1	
Surgical Assist	TBD	• Existing groups will stay at their current level until PMRC concludes its review (see Final Report section 4): FHA - Royal Columbia Hospital – Level 1 FHA - Surrey Memorial Hospital – Level 1
Thoracic Surgery	1	
Transplant	2	
Trauma	1	
Urology	2	• Includes Pediatric Urology
Vascular Surgery	1	