

**ENHANCING HEALTH SERVICES
IN REMOTE AND RURAL COMMUNITIES
OF BRITISH COLUMBIA
(NOVEMBER 1999)**

AN UPDATE ON FORMER RECOMMENDATIONS
(APRIL 2002)

**ENHANCING HEALTH SERVICE IN BRITISH COLUMBIA'S
REMOTE AND RURAL COMMUNITIES (1999)**

AN UPDATE ON FORMER RECOMMENDATIONS

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Enhancing Health Service in Remote and Rural Communities of BC (1999)

AN UPDATE ON FORMER RECOMMENDATIONS

Overview

The population of BC is currently estimated at 4,096,894 (P.E.O.P.L.E 26). The majority of the population resides in one of three large urban centres. The balance of the population continues to remain scattered over a large landmass characterized largely by mountainous and forested terrain.

Communities are small and are often separated by long distances. In many areas surface transport is difficult or non-existent. Winter transportation between communities can be especially hazardous and time-consuming. Transportation can also be particularly difficult for First Nations populations living on reserves.

With the concentration of the population there is an even greater concentration of specialist services. Tertiary services are confined to the urban areas. Secondary services are varyingly available in the medium and smaller communities in the province, but there are many smaller communities without easy access to secondary specialist services. Primary health care services are generally available throughout the province, but in remote and rural communities there are communities too small to support a general practitioner.

The health status of remote and rural populations is inferior to that of urban populations. The aboriginal population, which is concentrated in the more remote areas of the province, has a health status that continues to remain inferior to that of the non-aboriginal population residing in the same area.

The 1999 plan to enhance health services in remote and rural communities of BC was developed by the Provincial Co-ordinating Committee for Remote and Rural Health Services (PCCHRRHS) with input sought from the following stakeholders:

- health authorities;
- professional associations;
- tertiary care facilities; and,
- educational institutes.

The plan detailed the committee's direction with respect to the provision of health services in remote and rural areas of BC with a particular focus on the following five areas:

1. Primary health care services
2. Aboriginal health services
3. Mental health services
4. Service coordination including – getting services to residents
5. Centralized services – getting residents to services

The Provincial Coordinating Committee for Remote and Rural Health Services made numerous recommendations in the 1999 plan for improving health services in remote and rural BC. The following is an update on what has transpired since the submission of those recommendations.

Recommendation Overview

1. Primary Care

The delivery of primary health care in Canada has been under examination by governments and professional organizations for several years. The advantages of a reorganization of primary health care into a care system which integrates primary medical care with such other services as home, community, and primary care nursing, social services, dietary services, mental health services, physical therapy services, etc. have been articulated in a series of documents during the past five years.

Strengthening primary health care involves responsibility for the health of a defined population. Shared responsibility through the use of multi-disciplinary teams and alternate funding methods can support enhanced primary health care. For example, in small remote communities, establishing service contracts between providers and governing bodies, and between providers and patients, may support provision of primary care where traditional funding methods are not sufficient.

The establishment of primary health care organizations, which embody the concepts outlined above, may address many of the current barriers to the satisfactory recruitment and retention of physicians and other health care providers. Practice in small and remote communities would be seen as an acceptable career path rather than a second best to urban practice, or worse still, an alternative not to be considered at all. Opportunities would be created to recruit physicians who have a particular interest in the special practice opportunities provided. Opportunities would also be created to recruit nurses who have a particular interest in special practice opportunities and advance practice in rural/remote area.

1999 RECOMMENDATIONS:

- **Health Authorities, working with health care providers, establish a primary health care plan for each community that incorporates innovative ways of delivering health services and would address the issue of deployment of health care providers to meet the needs of the community.**
- **The Ministry of Health explore development of systems and funding options that foster the concept of improved primary health care.**

UPDATE

- In response to the 1997 National Forum on Health recommendations, Health Canada established the Health Transition Fund, which supported provinces in testing new approaches in the areas of home care, pharmacare, integrated service delivery and primary health care. In 1998, the BC Ministry of Health was awarded funding from this fund to launch the Primary Care Demonstration Project

(PCDP). The goal of the PCDP was to test new and innovative models of primary health care delivery (PCDP Year One In Review: May 200)
<http://www.healthplanning.gov.bc.ca/care/primdemo/pcdp.pdf>

Eight (8) primary care organizations were established in BC through the Health Canada Transition Fund. These sites are located in:

- Brookswood Family Practice - Langley BC
- Chase Health Centre - Chase BC
- Fort Family Practice - Fort Langley
- James Bay Community Centre – Victoria, BC
- Spectrum Health – Vancouver, BC
- Surrey Mental Health and Medical Centre – Surrey BC
- Family Practice Centre – UBC Vancouver, BC

As well as the above, funding for upgrading technology was allotted to the Park Avenue Medical Centre – Terrace, BC

- In addition to the eight (8) PCDP sites, the Ministry of Health Planning is currently in the midst of establishing new sites in the following regions:
 - Interior Health Region – Logan Lake, Ashcroft/Clinton and Kaslo
 - Vancouver Coastal Health Region – Downtown East Side
 - Northern Health Region – Francois Lake
 - Fraser Health Region – Agassiz

Next Steps...

To ensure the sustainability and affordability of British Columbia's primary health care system, new ways of delivering care need to be made available to the province's primary health care providers. The province is currently submitting a proposal to the Health Canada Primary Health Care Transition Fund (PHCTF), requesting approximately \$74 million for the planning, implementation, and evaluation of three strategic approaches that will:

1. Increase the proportion of the population able to access primary health care organizations which are accountable for the planned provision of a defined set of comprehensive services to a defined population;
2. Increase emphasis on health promotion, disease and injury prevention and chronic disease management;
3. Expand 24/7 access to essential services;
4. Establish interdisciplinary teams of primary health care providers who will ensure that the most appropriate care is provided by the most appropriate provider;
5. Facilitate coordination and integration with other health services (e.g., in institutions and communities).

Funding will be used only for transitory costs needed to assist and facilitate change in the organization and delivery of primary health care in BC. The BC Ministry of Health Planning will support regional health authorities to implement and enhance the delivery of primary health care programs in BC. In addition, the Ministry will develop its own infrastructure to ensure that appropriate and sustainable primary health care services will be supported beyond the term of the PHCTF funding period.

2. Aboriginal Health Services

The health status of aboriginal people in British Columbia does not match that of the non-aboriginal population sharing the same environment. "Aboriginal peoples in British Columbia, as elsewhere in Canada, experience very significant health status inequalities in comparison to the general population. Although Aboriginal people have made significant gains in recent years, they still have a much shorter life expectancy and a much higher rate of death than the general population" (*A Report on the Health of British Columbians*. Provincial Health Officer's Annual Report, 1996).

"The factors that determine poor health status in Aboriginal communities are the same as those in other populations - poverty, unemployment, lack of education, inadequate housing, family violence, poor diet, smoking, and lack of empowerment" (*A Report on the Health of British Columbians*. Provincial Health Officer's Annual Report, 1996).

The provision of health services to aboriginal peoples requires meaningful involvement of aboriginal people in the planning, implementation and provision of services. Services directed towards aboriginal people need to be developed in areas of need. Services in all communities must be culturally sensitive.

1999 Recommendations:

- **Health Authorities actively encourage the involvement of the aboriginal community in planning and implementing health services.**
- **Health Authorities work with aboriginal groups for improvement of the health of aboriginal people and develop a primary health care plan designed to meet those goals.**
- **Health Authorities increase understanding and sensitivity of health professionals to the unique needs of aboriginal people.**

UPDATE:

- Addressing Aboriginal peoples as a specific health population group is currently mandatory for all health authority planning. Health authorities were initially required to submit a health plan specific to Aboriginal health in the summer of 2001. As a

result of Health Authority restructuring, the deadline for plan submission has been extended to September 2002.

- *Aboriginal Health Conference* - January 2002. The purpose of this conference was to bring stakeholders together to review existing health service needs and to develop means for improving the service delivery for aboriginal populations residing in rural and remote locations throughout BC. Representatives from all sectors attended this conference. Delegates left with an increased understanding and knowledge with respect to Aboriginal health needs, resulting in an increased capacity to better inform health planners within their respective organizations
- The First Nations Chiefs Health Committee works with federal and provincial health agencies to improve Aboriginal health status through advocacy, identification and analyses of service delivery models and coordination of programs and resources.
- Rural and Remote Aboriginal Health Services Committee – hosted their most recent meeting in December 2001. This committee seeks to coordinate federal and provincial activities to improve services in remote and rural communities. A number of collaborative projects are under discussion.
- Provincial Health Office – PHO is currently developing a report focused on the health and well-being of Aboriginal British Columbians. With a planned release in the summer of 2002, the report will provide baseline information on Aboriginal health, and should inform the development of Aboriginal health plans by provincial health authorities.
- Urban Aboriginal Health Centres: There are currently four Urban Aboriginal Health Centres in BC: Prince George, Kamloops, Nanaimo, and Vancouver. These centres provide a range of primary treatment, counselling, and referral services particular to the needs of local Aboriginal populations. At the time of this update, annual funds allocated to these centers amounts to approximately 1.4 million.
- There has been considerable interest in, and work towards, establishing an Urban Aboriginal Health Centre in Prince Rupert; with participation from local Aboriginal communities, health authorities, MOH and Health Canada. The new Northern Health Authority will have lead responsibility if this project is identified as a regional priority.
- Chase Primary Care Organization (PCO) – Director of Aboriginal Health Division (MOHP) met with the Executive Director of Chase PCO to discuss increased input from members the local Aboriginal community. A dialogue between the three (3) bands and the PCO has been initiated (2001).
- Aboriginal Health Service Contracts will be regionalized as of April 1, 2002. Health authorities will be required to manage provincial funding and all agency contracts associated with Aboriginal health within their respective regions.

- New Health Structure: Health Authorities indicating Aboriginal health focus to remain a priority through specific management appointments include:
 1. The Interior Health Authority – currently has a management position looking after the aboriginal planning process. Although this may be an interim position, it indicates effort and commitment on behalf of the new region.
 2. The Vancouver Coastal Health Authority – currently has in place a full time Director of Aboriginal Health.
 3. The Northern Health Authority – currently has in place a system to ensure that Aboriginal health issues are represented at the planning table.

Next Steps...

The current restructuring of provincial health authorities represents an opportunity to incorporate Aboriginal community involvement in the planning, delivery and evaluation of provincially funded health services.

As a stakeholder group, Aboriginal participation in the planning process would serve a number of functions:

- Provide a mechanism for health authorities to gain meaningful input from Aboriginal communities, thereby enhancing the region's ability to address the health needs and concerns of those Aboriginal populations within their respective regions.
- Collaborate with health authorities to develop and implement Aboriginal health service plans (should these remain a Ministry requirement);
- Facilitate coordination with other Aboriginal health programs, including those provided by First Nations.

3. Mental Health and Addictions Services:

Access to local and regional mental health and addictions services, both assessment and treatment of mental illnesses is a problem to many remote and rural communities. The availability of mental health professionals, including psychiatrists, psychologists, nurses and addictions specialists is a major constraint on access to appropriate services.

Other issues that are frequently raised include difficulties in provision of specialist services, a continuum of acute and community-based services and supports such as after care services, supportive housing, psychosocial rehabilitation and recovery options. Additional difficulties include transportation to access some services, ensuring privacy of patients in small communities and sharing of information including data reporting systems.

The Ministry of Health's Mental Health Plan is focused on addressing the need for improved mental health services, consistent with "*Best Practices in Mental Health Reform*" (<http://www.healthservices.gov.bc.ca/mhd/best.html>).

Recommendations

- **Health Authorities develop local mental health plans that build on existing strengths and implement the best practices in mental health.**
- **Existing services and programs, such as Health Match BC and the Psychiatric Outreach Program, to be examined as to how they might best support mental health programs.**

Update:

- In the last 5 years, rural and remote areas have become more self sufficient as a result of decentralized decision making, partnership with other health services, long term planning and new mental health funding.
- Positive mental health developments in rural and remote areas include: Peace Liard Tele Mental Health project, forensic liaison workers, supported housing, capacity, expansion in case management, strengthening acute care in the North West, tertiary care in Dawson Creek.
- In 2000 the Adult Mental Health Division held a forum on best practices in Mental Health for rural and remote areas. This two-day event was successful and has resulted in new approaches.

- Former health authorities were required to develop regional service plans specific to Mental Health. Following such, future mental health planning was integrated into each health authority's annual Health Service Plan.
- In June 2000, the document titled *Foundations for Reform: The Mental Health Policy Framework and Key Planning Tools* was disseminated to health authorities, which identified the designated responsibilities for the Ministry of Health and health authorities. The planning tools included a Mental Health Performance Monitoring Framework and a companion Resource Utilization Management Report for Mental Health Reform in British Columbia 1997/1998.
- To support performance management and accountability in the mental health system, it is critical that the information be collected and reported at the point of delivery. The MHS has a Community Patient Information Management System (CPIM) to assist mental health service providers and agencies in the collection and reporting information. However, the quality of the information collected through this system is often compromised because of lack of reporting by some service providers in some regions of the province. Since the quality of information collected by rural and remote service providers and agencies impacts the ability of the Ministry of Health Services to inform the health authorities and the public through the Performance Monitoring and Resource Utilization reports, it is important that service providers in isolated and remote settings comply with data collection and reporting through CPIM.
- Addictions services have been regionalized to health authorities effective April 1, 2002. Addictions best practices do exist and are available for health authorities as they plan for addictions services and contract with individual agencies. Health Canada has produced a best practices document for addiction treatment along with another specific to concurrent disorders, e.g., co-existing mental health and substance use disorders. Additionally, Ontario has produced a best practices planning guide for the development of withdrawal management services within rural and small urban communities.
- Psychiatric outreach services have been expanded.
- Tele-mental health – including telepsychiatry, has been introduced into 40 plus rural and remote communities through the Mental Health Evaluation and Community Consultation Unit (MHECCU). Access to this video-conferencing equipment will be available to others who would also benefit from video consultation. These projects provide linkages for assessment, education and consultation between local physicians, counselors, consumers and specialists in Vancouver.

- A pilot Tele-Nursing project operating in Anaheim Lake (funded through Health Canada) provides clinical consultation services for remote areas.
- The Early Psychosis Initiative has been piloted in the North. This initiative provides early identification of mental illness in young adults.
- There have been numerous housing developments in partnership with health authorities and BC Housing Management Commission in northern communities and in the Cariboo area.
- An innovative Emergency Psychiatric Services Initiative involving the designation of 11 community hospitals in rural/remote areas under BC's *Mental Health Act* will provide assessment and treatment for short periods of time to assist in initiation of timely treatment and stabilization of patients for transfer to a psychiatric unit if warranted. Some patients will be stabilized in their community and will not require transport to another facility. This will also assist in maintaining closer connection with families and effective discharge supports for patients. To-date, four hospitals have been designated as Observation Units under the *Mental Health Act*.

Next Steps...

- Mental Health Performance Monitoring Framework has been established and under the newly restructured health system, Performance Contracts and reporting expectations are now clearly in place.
- Effective September 1, 2002, the Community Patient Information Management System (CPIM) will be enhanced and replaced by the Mental Health Minimum Data Set (MH-MDS) and health authorities will be required to make sure that access, appropriateness and use of mental health services (including rural and remote areas) are reported through this information system.
- Addictions services, along with mental health services, have been given special attention in the health services agreement between the health authorities and the MHS. Health authorities will be accountable for specific addiction services outcomes along with reporting mechanisms that allow them to measure and report data indicators for these outcomes. One major outcome will be around maintaining and enhancing access to addiction services, a task that will be particularly challenging for rural communities.

- Along with the implementation of best practices, health authorities can enhance delivery of addictions services by focusing on standardizing client assessment, developing and implementing standard admission and discharge criteria, clarifying roles and responsibilities, re-shaping residential treatment services, constructing treatment services that are more flexible, offering clients more treatment options, promoting harm reduction strategies and enhancing access to methadone maintenance treatment. There is a need for service providers (health authorities) to develop strategies that respond to a wide range of diverse client needs by working together with other health and social agencies, focusing on early identification of substance misuse and adapting existing services to meet clients needs an developing population-specific programs.
- The health authorities will need to continue to report on the Addictions Information Management System (AIMS) and send a hard copy to the AIMS system of the MHS. Potential to integrate AIMS reporting with other systems is being explored and further information will be forthcoming.
- Crisis response and Emergency Mental Health Care needs to be enhanced in rural and remote areas of the province in keeping with best practices and MHS Emergency services standards for access to these services.
- Tele Mental Health is an important vehicle in rural/remote areas for provision of clinical services and education for mental health staff and physicians. A number of rural and remote areas have recently received equipment to develop Tele Mental Health services within their region. This needs to be strengthened in terms of standards development, performance and outcome indicators. The role of the Mental Health and Community Consultation Unit (Mheccu) in terms of Tele Mental Health and the evaluation and outcome results of the Peace Liard Tele Mental Health evaluation need to be closely examined and reflected in the development of these services.
- Outreach psychiatry services and funding through the Mental Health and Community Consultation Unit (Mheccu) need to be reviewed and compared with other health specialist traveling services. Standards and performance and outcome indicators must be developed. In addition, the following questions must be addressed: whether these funds should be regionalized, what are the outcomes, are health authorities and consumer families satisfied with the services, how does it tie in with Tele Mental Health and where are the existing gaps?
- Aboriginal Best Practices. Evidenced based knowledge about best practices of core mental health services relevant to the unique needs of aboriginal people need to be developed. In partnership with Aboriginal Health best practices will be developed in 2002/03.

4. SERVICE COORDINATION – GETTING SERVICES TO RESIDENTS

Recommendation (1)

Tertiary care centres, major urban hospitals and the UBC Faculty of Medicine work with local authorities to support enhanced specialty outreach services in a co-ordinated manner wherever they are needed in remote and rural areas.

UPDATE

- The support of enhanced specialty services is manifest in the increase payments for specialist on-call services for specialist in rural areas. Under the Rural Agreement between the Ministry of Health Services and the British Columbia Medical Association (BCMA) funds were set aside for improving core specialist services in more remote communities (see Appendix A).
- The Northern and Isolation Travel Assistance Outreach Program (NITAOP) provides funding to cover travel costs and travel time for specialists to travel into remote communities (see Appendix A).
- Rural Education Action Plan (see Appendix A).

Recommendation (2)

Current applications of Telehealth be reviewed and new applications for improving access to health care services be explored. Barriers to use of technology to enhance services in remote and rural areas of the province be identified and removed.

UPDATE

- Telehealth services have grown in the Province over the last two years under the Telehealth Branch of the Ministries of Health Services and Planning Information Management Group. Tele mental health programs have been developed in partnership between health authorities and the Adult Mental Health Division.
- Telehealth includes the provision of telemedicine programs providing consulting services from the Faculty of Medicine at UBC, and Vancouver Hospital and Health Science Centre, and Children's and Women's Health Centre to hospitals in rural areas in the Okanagan and the North. Specialty services include, psychiatry, pediatrics, trauma and critical care services and tele-radiology.
- In partnership with the Health Canada the provincial telehealth program is developing a telehealth infostructure and an electronic health record project. This project includes the provision of video conferencing and a development of a

network infrastructure. Other applications for this technology include the delivery of Continuing Medical Education programs in remote areas of the province.

- There are ongoing concerns about the cost of the consultations and the need to develop the technological infrastructure. With continual advances in technology, it is only a matter of time before technology will gain prominence in virtually every component of our health care delivery system. Health care is benefiting immensely from biotechnology, information technology, communications technology; and promises to produce further advances with the coming discoveries in nano-technology, genomics and proteomics. Future technology holds great promise health authorities working with the Ministry of Health Planning to develop a provincial technology management strategy for rural health services.

See Appendix A for current initiatives.

5. CENTRALIZED SERVICES – GETTING RESIDENTS TO SERVICES

Recommendation (1)

The Ministry of Health in conjunction with all Health Authorities in the province explore applications for telecare/self-care.

UPDATE

- The BC Health Guide program utilizing a handbook, a 1-800 phone line and the internet began in June 2001. It is designed to be an integral part of the B.C. health system, delivering reliable health information and advice right into peoples' homes - where they live and when they need it.
- The B.C. HealthGuide Handbook provides reliable information on over 190 common health concerns, including prevention, home treatment options and advice on when to seek help from a health professional.
- The B.C. HealthGuide NurseLine offers 24-hour, toll-free access to registered nurses specifically trained to provide confidential telephone health information and advice, including referral to appropriate care, decision support regarding treatment options and education about health services.
- B.C. HealthGuide Online links home computers and public Internet sites to a comprehensive and current Web site offering British Columbians authoritative, practical health information and advice on over 2,500 health topics, tests and procedures.

Recommendation (2)

Options to be developed to address transportation issues, in conjunction with municipal governments and other committees, such as the Trauma Advisory Committee and the Intensive Care Committee, as appropriate.

UPDATE

- The British Columbia Ambulance Service (BCAS) provides provincial emergency transportation. BCAS provides both ground and air transportation in rural and remote areas. Paid and non-paid staff (volunteer) is utilized in the operations of existing stations. A study designed to survey patients and identify opportunities for reducing transfers services in the North West was carried out in 2001/2002. The Northern Health Authority performed this study. For results contact the health authority at: (250) 565-2649.
- The Trauma Advisory committee works across the province with hospitals and health authorities to provide access to trauma services in various regional locations.
- The BCbedline was established in August 2001 to facilitate the transfer of patients to appropriate hospital beds around the province and repatriating them once their condition is stable.
- The Travel Assistance Program continues to assist residents in defraying the cost of travel to medical services not classified as an emergency.
- Local transportation continues to a problem in those areas where municipal transportation systems do not exist.

Recommendation (3)

The development and use of appropriate data sets to address specific issues affecting the delivery of health services to residents of remote and rural communities be encouraged.

- To support performance management and accountability in the mental health system, it is critical that the information be collected and reported at the point of delivery. The ministry has a CPIM (Community Patient Information Management System) system to assist mental health service providers and agencies in collecting and reporting of information. However, the quality of the information collected through this instrument is often compromised because of lack of reporting by some service providers in some regions of the province. Since the quality of information collected by rural and remote service providers/agencies impacts the ability of the Ministry of Health Services to inform the public through the Performance Monitoring and Resource Utilization reports, it is important that service providers in isolated and remote settings comply with data collection and reporting through CPIM.

Recommendation (4)

An annual report of the committee be provided to the Deputy Minister of Health evaluating access to health care services by residents of remote and rural communities of BC; identifies issues affecting their provision of health care services; makes recommendations for addressing these issues; and monitors the effectiveness of any changes.

UPDATE

- Reports on meetings issued, but no annual report was issued.
- The provincial coordinating committee is no longer functional.

ADDITIONAL INITIATIVES SINCE 1999:

- The "National Health Summit" took place in Prince George, January 18-20, 2001. A copy of the summit report containing 200 recommendations can be found at: <http://www.city.pg.bc.ca/healthsummit/>
- The National Health Summit developed resulted in the establishment the Canadian Rural and Remote Health Association. The "Canadian Rural and Remote Health Association Founding Conference" planned for January 18-19, 2001(Prince George, BC) has been cancelled as of December 6, 2001. Further information on this Association can be found at: <http://www.res.unbc.ca/crrhaconference/>
- The Canadian Rural and Remote Health Association is proposing the development of an Atlas of Rural and Remote Health in British Columbia. The proposal for this "Health Atlas of Rural and Remote Communities in British Columbia: Phase One" was developed by Alex Michalos and submitted for funding consideration to the CIHR. Funding has not yet been confirmed.
- The BC Rural Conference at Silver Star Mountain in Vernon, April 27-28, 2001. The conference was organized by the BC Rural Team (Federal/Provincial Committee). It was one of four rural dialogue gatherings held across Canada this year by various rural teams. Reports from the event include *Summary of Discussion from Health Canada on Rural Health and Primary Care Workshops*.
- The Ministries of Health are working to improve the delivery of health services to all BC residents. For an updated account on all programs currently in place to enhance rural and remote health service delivery (see Appendix A).

Next steps....

Initiatives to meet the New Era Commitments involve:

1. Establishing a Reference group to collaborate with ministry personnel in the development of the new Rural and Remote Health Initiative.
2. Building upon existing telehealth programs.
3. Expanding the telehealth/telemedicine projects in partnership with Health Canada.
4. Working with all government sectors and NGOs to keep abreast of the strategies and programs being established in the North – e.g. Health Canada’s plan to broaden primary care services for Aboriginal people and the development of Medical school residency in Prince George.
5. Assessing the impact of reduced funding for home and community care services in rural and remote locations. Focus – how to maintain community care services in light of fiscal restraint.
6. Reviewing the impact of fiscal restraint on rural and remote areas where strategies using economies of scale and shared services (urban strategies) will have limited application.

2002 Rural Health Initiatives driven by the New Era Commitments
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1. In collaboration with the Ministry of Advanced Education (Skills Development and Labour), develop a 10-year human resource plan that properly provides for the training, recruitment and retention of physicians, nurses, specialists and other health care providers in each area of the province, and that addresses critical skills and staffing levels in under-serviced areas.
2. Establish a Rural and Remote Health Initiative to ensure all families get the care they need, where they live and when they need it.
3. Increase the number of residency positions in BC and increase training space and recruitment of foreign trained physicians.
4. In conjunction with the Ministry of Advanced Education, develop a Rural and Remote Training program and provide forgivable student loans to students attending accredited nursing and medical schools – provided they practice for five years in underserved communities in British Columbia.
5. Introduce a Rural and Remote Training Support Program that provides financial assistance and travel assistance to health care providers currently practicing in rural and/or remote communities who want to upgrade their skills and training.
6. Increase locum support to relieve pressure and reduce workloads, to enhance health care professionals’ quality of life.
7. With Ministry of Health Services, develop a travel assistance program to reduce rural patients’ transportation and lodging costs to receive treatment that is not locally available.

PROGRAMS CURRENTLY IN PLACE

1. Physician Recruitment and Retention Program (PRRP)

The *Modified Physician Recruitment and Retention Program* provides funding for recruitment, retention and on-call service in rural and small urban communities. <http://www.healthplanning.gov.bc.ca/rural/physrecruit.pdf>

The purpose of the *Modified Physician Recruitment and Retention Program* is to offer a number of premium incentives to enhance the supply and stability of physician services in rural and small urban communities throughout the province.

The program allows Health Authorities to:

- provide retention premiums for general practitioners and specialists;
- offer \$10,000 signing bonuses to new doctors recruited by health authorities;
- provide payments to general practitioners and specialists who provide on-call services;
- provide enhanced Continuing Medical Education (CME) funding; and
- support physician advanced practice and postgraduate training.

2. Recruitment Of Foreign Trained Physicians

A program put in place to assist Health Authorities in their efforts to recruit foreign trained doctors to practice in rural and remote communities. The program sets out specific criteria that health authorities are to follow to enable them to recruit new physicians. <http://www.healthplanning.gov.bc.ca/rural/foreignmd.pdf>

3. Emergency Medical Coverage Program (EMCP)

The purpose of the Emergency Medical Coverage Program is:

1. To provide residents within NIA communities with 24-hour access to physician services, and to encourage the retention and recruitment of physicians in NIA communities.
2. A community must be designated as a NIA (Northern and Isolation Allowance) community to qualify for EMCP funding. EMCP is offered in return for guaranteed physician availability such that the people of the community have adequate access to physician services outside regular office hours. The physician(s), the health authority and the community will determine the requirements for physician availability.

<http://www.healthplanning.gov.bc.ca/rural/emcpolicies.pdf>

4. Interim Urban Specialist Availability Program (IUSAP)

The Rural Health Office is currently managing this program. While a long-term and comprehensive solution has not been finalized, the IUSAP was implemented to ensure urgent and emergent patient service is stabilized.

The program is based on the on-call payment scheme under the PRRP program for rural/remote communities. There are two Availability Groups: (1) Specialty areas include psychiatry, general surgery, anaesthesia, paediatrics, internal medicine, orthopaedic surgery & obstetrics/gynecology. Specialists are required to and are able to provide 24-hour care, 7 days a week, 365 days a year, and (2) Specialty areas include the same as the former, but availability is less than 24/7, 365 days per year.

5. Travel Assistance Program (TAP)

This program began in June 1993. It is a corporate partnership administered by the Ministry of Health. TAP, with co-operation from physicians, facilitates travel fare discounts offered by public and private sector transportation partners, for those who must travel to obtain non-emergency medical care not available in their own community. <http://www.healthservices.gov.bc.ca/msp/infoprac/rural.html#locum>

6. Northern and Isolation Committee (NIC)

The NIC advises the Medical Service Commission (MSC) on the funding and administration of NIA (Northern and Isolation Allowance), the Northern Isolation Travel Assistance Outreach Program (NITAOP) and the Northern and Rural Locum Program (NRLP).

- **The Northern and Rural Locum Program** - The Government and the BCMA acknowledge that providing sufficient support to allow rural physicians to have reasonable periods of leave from their practices for such things as CME, vacation and health needs is essential for the recruitment and retention of physicians in rural practice. The goals are to ensure community needs are met, physicians' health is protected, continuity of quality care, and the maintenance and enhancement of the skills needed in rural practice. This program, administered by MSP, was established to assist physicians practicing in small communities to secure subsidized vacation relief. Physicians may access up to twenty-eight days annually in 5-day minimum blocks.

<http://www.healthservices.gov.bc.ca/msp/infoprac/rural.html#locum>

- **Northern Isolation Travel Assistance Outreach Program (NITAOP)** – The *NITA* component provides funding for specialist travel expenses, funding is from the Available Amount and was implemented prior to 1989.

The *POP* component of the program provides funding for general practitioner travel expenses to communities without general practitioner services and provides a travel time honorarium for general practitioners and specialists traveling under POP, was implemented in July 1998 and has a budget of \$635,000 for 2001/02. The New Era commitments to Rural health involve access issues to ensure all families get the care they need, where they live and when they need it. The NITAOP program provides a very valuable service and access to underserved rural and remote communities who do not have specialist or general practitioner services. Many physicians will not travel to the small and rural communities to provide service if they do not receive the travel expense reimbursement and/or the travel time honorarium. With the current fiscal restrictions presented to health authorities, the services of specialists will tend to be centralized to urban areas, making an increased need for this program to be maintained.

<http://www.healthservices.gov.bc.ca/msp/infoprac/rural.html#locum>

7. Subsidiary Agreement For Physicians In Rural Practice

The BCMA and the Ministry of Health signed the Subsidiary Agreement for Rural Physicians on June 9, 2000. The purpose of this Agreement is to enhance the availability and stability of physician services in rural and remote areas of British Columbia by addressing some of the uniquely demanding and difficult circumstances attendant upon the provision of those services by physicians. Although the first agreement expired on March 31, 2001 negotiations are ongoing to permanently put in place aspects this plan. <http://www.healthplanning.gov.bc.ca/rural/ruralagr.pdf>

Programs under this agreement include:

- A. Rural Health Video Network Link Project** - The purpose of this project, funded through the *Rural Subsidiary Agreement*, is to evaluate the feasibility and cost effectiveness of video teleconferencing technology for the purposes of (a) clinical consultation and (b) health professional education in rural BC. The objectives of this project are:
- to provide clinical consultation pipeline through videoconferencing between Vanderhoof and the nursing station at Stoney Creek;
 - to evaluate the technological feasibility and cost effectiveness of the electronic clinical consultation process for the First Nations community of Stoney Creek;
 - to assess and prioritize the professional educational needs of the health professionals in the communities of Vanderhoof and Stoney Creek;
 - to develop a series of Continuing Health Education (CHE) programming, with a mixture of CD ROM, Internet, videoconferencing, on line rounds, and other

electronic based educational interventions to address the prioritized educational needs of the communities;

- to evaluate the effectiveness of the CHE programming in fulfilling the needs of the communities;
- to test the usage of the Provincial Learning Network (PLNet) for real time, point to point videoconferencing for clinical service delivery and CHE programming in BC.

B. Rural Undergraduate/Post Graduate/Specialty Training (Rural Education Action Plan) - The *Rural Agreement* was structured to create a joint initiative between the British Columbia Medical Association (BCMA) and government to improve the educational opportunities for rural physicians, both for those in training and those in practice. This section identified a budget of \$1 Million for rural education and training. This has developed into the Rural Health Education Action Plan. The goals of the Rural Education Action Plan are:

- to increase the number of students likely to take up rural practice;
- to increase exposure and opportunities to practice in rural communities for medical students and residents;
- to increase the numbers and support to rural physician teachers;
- to increase the training available to established rural practitioners;
- to reduce the feeling of isolation and the inability to re-enter urban practice, which inhibits many physicians from rural practice in the first place;
- to facilitate specialty re-entry and enhanced training opportunities for existing rural physicians.

8. Advanced Nursing Practice (ANP)

- The ANP research project is a qualitative, exploratory study designed to obtain data to support decision-making regarding new nursing roles and service delivery models in BC.
- Co-sponsors of this research include the Registered Nurses Association of BC, the University of Victoria, the Capital Health Region, and the Ministry of Health Planning.
- Co-funding agencies include the Canadian Health Services Research Foundation, the BC Health Research Foundation and the Nursing Research Fund.
- A Reference Group has also been formed to provide consultation, guidance and feedback at strategic points during the research project.

9. BC HealthGuide

The BC HealthGuide program is designed to deliver reliable health information and advice to individuals in their own homes. BC's professional associations of physicians, nurses and pharmacists endorse the program. The following BC HealthGuide services are available:

- The BC HealthGuide Handbook provides reliable information on over 190 common health concerns, including prevention, home treatment options and advice on when to seek help from a health professional.
- The BC HealthGuide NurseLine offers 24-hour, toll-free access to registered nurses specifically trained to provide confidential telephone health information and advice, including referral to appropriate care, decision support regarding treatment options and education about health services.
- BC HealthGuide Online links home computers and public Internet sites to a comprehensive and current web site offering British Columbians authoritative, practical health information and advice on over 2,500 health topics, tests and procedures.

TELEHEALTH PROGRAM

- **Liberal New Era Document** – “increase IT funding and digital infrastructure support to facilitate telehealth options to expedite and improve treatment, and reduce travel for northern and rural residents.
- **Telehealth** – the use of communications and information technology to deliver health services and transmit health information over both long and short distances.

In August 2000 BC was awarded funding for 8 project proposals submitted to Health Canada. These include:

- **B.C. Telehealth Program** - Lead by the Health Association of British Columbia, the goal of this program is to establish a multi-disciplinary electronic network of clinical, continuing education and administrative telehealth applications. Activities will take place in the Capital Health Region, East Kootenay, Okanagan Similkameen, North West and Northern Interior regions of the province.
<http://www.healthservices.gov.bc.ca/bctelehealth/>
- **Bridges to Better Child Health: Networking Knowledge and Resources to Improve the Health and Health Care of B.C. Children and Families** - The Children's and Women's Health Centre in Vancouver will be responsible for this program. The program builds on an existing model in Ontario - the electronic Children's Health Network. Project focus is the development of an infrastructure for sharing population-based Electronic Health Records.
- **Central BC & Yukon Telemedicine Initiative** -The Thompson Health Region will develop a telemedicine system to enable specialist medical services and health information to reach rural and remote areas of British Columbia and the Yukon.
- **Development and Implementation of an Integrated Community Mental Health System** - The Capital Health Region, in partnership with the Victoria Cool Aid Society, will be involved in the development and implementation of a standards-

based, public domain software package for use in small to medium size health and community agencies.

- Healthlink -The Okanagan-Similkameen Health Region will be implementing a new and innovative fully integrated information system designed to assist seniors and health professionals in coordinating health services and raising awareness of existing community services. A toll-free number and a local number will provide the service.
- Provider Registry - Under the direction of the Ministry of Health Services, the Provider Registry encourages the implementation of Electronic Health Records (EHR). These records are standards-based, centralized, electronic application that can be implemented anywhere in Canada and expanded for use as a national registry.
- SYNAPSE Multi-Jurisdictional Mental Health Information Systems Project - This project includes Electronic Health Record applications and the integration of key data sources across the continuum of mental health care, such as the proposed BC Mental Health Data Warehouse, Health Registry and PharmaNet. It also advances standards for data, technology and security.
- Telementalhealth Services in British Columbia and the Yukon - Expanding on their pilot project in the Peace Liard region, the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia will continue to implement tele-psychiatry and distance education programs in under serviced areas of British Columbia and the Yukon, using video-conferencing technology.

Rural and Remote Definitions:

Primary Health Care

- (1) Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of self-reliance and self-determination. . . . It is the first level of contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process. (World Health Organization)
- (2) Primary Health Care is that level of care “where the health system is entered and basic services received and where all health services are mobilized and coordinated.”
(The Dimensions of Primary Care: Blueprints for Change. A.W. Parker in: Primary Care: Where Medicine Fails, Andepoulos S. ed; Wiley & Sons, 1974)
- (3) “Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford. It forms an integral part of the country’s health care system of which it is the nucleus ... It is the first level of contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process ... Primary Health Care addresses the main health problems in the community, providing promotive, preventative, curative, supportive and rehabilitative services accordingly.”
(*Primary Health Care*. A joint report by the Director General of the WHO and the Executive Director of the United Nations Children’s Fund. Alma Ata: World Health Organization, 1978.)

Primary Medical Care

Primary medical care consists of a first-contact assessment of a patient and the provision of continuing care for a wide range of health concerns. Primary medical care includes the diagnosis, treatment and management of health problems (conditions); prevention and health promotion; and ongoing support, with family and community intervention where needed.
(Canadian Medical Association)

Remote

A long way from a tertiary care center. (may or may not be rural)

Rural Area

Means territory not organized as a municipality. (Interpretation Act RS Chap 238, section 29)

Rural

- (1) A non-urban area where most medical care is provided by a small number of GPs/FPs with limited or distant access to specialist services and high technology health care facilities. (Rourke J. In search of a definition of 'rural'. Can J Rural Med. 1997; 2(3): 113-115)
- (2) In, of, suggesting the country as opposed to urban. (Concise Oxford Dictionary)
- (3) Communities of up to 10,000 Report of the Advisory panel on the Provision of Medical Services in Underserved Regions. (Ottawa: Canadian Medical Association; 1992)

Rural Remote

Rural communities about 80-400 km or about one to four hours transport in good weather from a major regional hospital. (Rural Committee of the Canadian Association of Emergency Physicians)

Rural Isolated

Rural communities greater than about 400 km or about four hours transport in good weather from a major regional hospital. (Rural Committee of the Canadian Association of Emergency Physicians)

Rurality

Rurality is assessed using six weighted variables: remoteness from a basic referral centre, remoteness from closest advanced referral centre, drawing population, number of general practitioners, number of specialists and presence of an acute care hospital. (Leduc E. Defining Rurality: a General Practice Rurality Index for Canada. Can J Rural Med. 1997; 2(3): 125-131)

Urban

Within 120km and 1.5 hours travel time of a tertiary care center