Rural Health Services in B.C.: A Policy Framework to Provide a System of Quality Care

Executive Summary

Strategic Context

The focus of this paper is on the wide variety of challenges and strategies to improve access to health care in rural and remote communities. While there are many benefits to rural life, living in rural British Columbia clearly presents some unique challenges of providing appropriate access to health care. These challenges stem from multiple factors: geographic remoteness, long distances, low population densities, less availability of other providers and inclement weather conditions. The presenting challenge is how best to meet the range of health service needs for rural and remote communities.

*Rural Health Services in B.C.: A Policy Framework to Provide a System of Quality Care* is a planning and action framework that will be used to enable a consistent approach to addressing health service priorities through a rural lens. Policy directions will be built around four categories: understanding population and patient health; developing quality and sustainable care models; recruiting and retaining engaged, skilled health care providers; and supported by enabling IT/IM tools and processes that together will allow innovation and flexibility in responding to the diversity of geographies across the Province of British Columbia.

The goals and objectives of the planning and action framework align with the strategic direction for the health system in *Setting Priorities for the B.C. Health System* (Priorities 2, 3, 4, and 7) and the areas of focus set out in the *B.C. Health System Strategy Implementation: A Collaborative and Focused Approach* published in April 2014 by the B.C. Ministry of Health. They also align with the three overarching goals of the *Triple Aim* (developed through the Institute of Health Improvement):

1. Improving the health of populations;
2. Improving the patient experience of care (including quality and satisfaction), to which B.C. has recognized the additional requirement of improving the experience of delivering care for providers and support staff as critical to patient-centred care built on efforts of those who deliver and support health services; and
3. Reducing the per capita cost of health by focusing on quality (especially effectiveness and appropriateness) and the efficiency of health care delivery.
The Case for Change

The health care needs of the population in B.C. are grouped into four areas: Staying Healthy, Getting Better, Living with Illness or Disability, and Coping with End of Life. The presenting challenge is how best to meet the range of health service needs set out above for rural and remote communities.

Generally speaking, individuals who reside in predominantly rural communities tend to have comparatively poorer health outcomes and socioeconomic status compared to their urban counterparts. The populations of rural British Columbia are often small, dispersed and fluctuating in number. Rural British Columbia is home to many First Nations communities and Aboriginal peoples, and a large percentage of the rural population identifies as Aboriginal.

Against this health status backdrop, three specific service challenges stand out in the context of rural and remote communities: ensuring access to quality primary care services; ensuring pathways to accessing specialized perinatal, medical, and surgical services when they are required; and how best to support aging in place. Access to specialized acute care services and access to ancillary health services is especially challenging, so residents are often required to travel for care.

The unique character and demands of rural life require that health services are guided by a common set of quality dimensions as well as some specific service delivery principles:

- Population Health Need
- Shared Responsibility
- Flexibility and Innovation
- Team Based Approaches
- Close to Home
- Cultural Safety

Health authorities will need to structure their services more consistently with the framework for the rural/small rural/remote areas for specific community designations across the health authorities and be required to outline pathways for patients that enable access to higher levels of care in larger population centres.

Health authorities have a key accountability to provide public health and primary care services that improve the health of the population and to work with individuals and communities to foster healthy behaviours.
Integrated primary and community care practice is the foundational building block to providing care services in rural and remote areas. This model has the capacity to: address longitudinal health care needs; meet the needs of specialty populations (including perinatal care, chronic medical conditions, frail elderly, cancer care, mental illness, substance use, and palliative care); and respond effectively to urgent and emergency care where required for short periods of time with effective clinical pathways and linkages to higher levels of services.

The integrated primary and community care practice model – with the right skill mix and number of health providers – has a number of implications:

1) The need for generalist health care providers.
2) The providers have linkages to specialized expertise at regional or provincial service centres.
3) The providers facilitate patients’ access to high quality perinatal care.
4) The providers facilitate patients’ access to specialized geriatric and psychogeriatric services and home and community care residential care services.
5) There are efficient patient-centred pathways to medical and surgical services.
6) There is access to emergency services.

The need for a generalist practice in rural and remote communities is a practical reality and must be balanced against the requirement for quality and safety of those services. In order for generalist health service providers to be appropriately supported in rural communities, access to specialist consultations and services in both planned and emergent situations is critical to enabling quality and safety in service delivery.

Primary maternity care in rural and remote communities is complex, involves a variety of disciplines and scopes of practice in providing services, and it involves unique issues that must be addressed as part of an effective rural health services strategy including:

- Recruiting, training and retaining qualified staff to provide community-based perinatal care in rural and remote communities;
- Ensuring access to emergency delivery through C-section where there is lack of general practitioner/surgeon and/or general practitioner/anaesthetist; and
- Ensuring access to pre and post natal specialist services for at risk women and infants.

With an aging population in many rural and remote communities, there are more people having difficulty coping with activities of daily living because of health-related problems or a life-threatening illness. They require access to a number of publicly subsidized services including home support, adult day services, and residential care. In this context, it is essential to determine what is the practical capacity to provide access to specialized geriatric or
psychogeriatric services and home and community care services in rural, and especially, remote communities and in their absence, what are realistic, innovative, and flexible local solutions and/or pathways for patients to access services elsewhere.

Access to trauma services in rural and remote British Columbia is a particular concern given the prevalence of resource-based industrial employment and the incidence of transportation-related injuries. In rural and remote communities, the following are critical considerations:

- Clear patient transfer pathways to trauma care centres bypassing centres that do not have the capacity to provide the necessary trauma care.
- Access to pre-hospital care, stabilization, and patient transportation to higher levels of care as quickly as possible.
- Access to specialized knowledge and expertise to guide and support generalist health care providers.

The pathways to access these specialized services must be clear and reliable, whether the services are accessed within the health authority’s regional health service delivery system or through provincial centres within the tertiary/quaternary care and academic health science centre system.

For patients that require medical and surgical care that can only be provided in an acute care hospital environment, the immediate focus of the rural strategy will be:

- Clarifying and publicizing the regional distribution of hospital services and any plans for changes.
- Clarifying referral pathways and timelines.
- Focusing on and reporting the level of and quality of services provided in rural hospitals.

Regional health authorities will adopt a consistent process across their rural communities to enable local community level partnerships between local health authority leadership, physicians, health professionals, patients, caregivers and community leaders to design Integrated Primary and Community Care Practices across rural and small rural communities.
Critical to this approach is the combining of the right skill mix and numbers of health providers to meet the primary health care needs set out above including family physicians, nurse practitioners, community care nurses, allied health staff, home health support staff, mental health and substance use staff, and public health staff, as well as specific issues such as:

- **Physicians**: The identified need to define the role of a rural physician and to ascertain the distinctive skills required when working in smaller communities.
- **Nurses**: The need to: meet current and future demands; improve access to education; consider a clinical component; and, for a learning assessment for registered nurses who have worked in remote communities outside of British Columbia. The integration of nurse practitioner roles into B.C.’s health system needs to be accelerated.
- **Physicians, nurses, and allied health professionals**: The integration into rural remote areas and support and incentive programs.

Given the current challenges to providing care in rural areas, technology innovations can help rural communities to improve their health and health care. To maximize benefits, health professionals working in rural areas are already engaged in effecting change. Interdisciplinary teams supported by information management and technology (IM/IT) enabled tools can bring value to underserved rural communities.

The electronic medical record (EMR) is essential to improve the quality of care provided within the primary care environment.

Telehealth requires setting out a system wide approach; a plan for the use of telehealth in rural and remote areas; and, standardizing its usage in rural areas.

### The Next Steps - Focusing and Reenergizing the Commitment to Rural Health Care

The recommendations put forward in this paper push the boundaries of what we have been doing so far and emphasize a need for timely, short and longer term action. I want to emphasize that we are putting forward a range of proposed actions that we think will improve our health services in a number of important areas and better position our health system to meet increasing demand from key patient populations. The actions proposed would be undertaken opportunistically building on initiatives and innovative service delivery already underway across B.C., but also will require a systematic approach to change that builds a truly patient-centred system of care ([The British Columbia Patient-Centered Care Framework](#)).
You may have different views on the proposed action, how to improve the system or how to implement these recommendations and that is precisely what we are testing out by posting these papers. Your feedback will be part of a healthy and thoughtful discussion of these recommendations. Over the coming three months my aim is for us to achieve a good level of consensus across key partner and stakeholder groups of what the final set of specific actions should be; and then, for us to move forward collaboratively to figure out the detail, the how and the timing of implementation linked to better meeting current and emerging needs in a timely way. Patients as Partners will be an important part of this process.

I want to assure you the implementation of the final set of recommendations will allow enough flexibility for a diversity of implementation approaches across communities but that I also intend to push us to create a truly integrated system of health care that works for patients and not just for us. Your input, creativity and innovation in shaping and implementing the final set of recommendations at the local, organizational and provincial levels will bring new solutions and enrich our B.C. health system.

In moving forward, the Ministry of Health is assigning specific policy directions to the practice level, organizational level, and provincial level of the health system. The following policy directions apply specifically to the communities classified as rural, small rural and remote by regional health authorities (see Appendix A). These policy directions build on and add to work currently underway and will be implemented as part of the formal regional health authority working plans starting April 2015. The First Nations Health Authority will be a key partner in working with the regional health authorities to apply these directions to close health gaps for First Nations communities.

1. Practice Level - Service Delivery

1.1 Population Health, Health Prevention and Wellness: In 2015/16, regional health authorities will develop three year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population. These plans will be developed in collaboration with local communities. The plans will be referenced in their service plans, be available on the health authority website, and attached to their detailed service and operational working papers. The first set of community plans will start 2016/17, be refreshed every three years with updates on progress provided annually. These plans will:

- Provide health status profiles for individual communities that will be refreshed every three years to assist in planning, targeting efforts and tracking progress.
• Identify specific areas where they are working with communities, departments across government and other partners as they undertake work to address broad determinants of health, such as education, housing, healthy infrastructure, and food security.
• Identify specific actions and initiatives to promote healthy behaviours in collaboration with communities to promote and support individual responsibility for health and healthy living.
• Reference specific actions and initiatives that are being undertaken in collaboration with Aboriginal communities to close health status gaps and efforts to encourage holistic approaches to health and wellness that incorporate traditional Aboriginal healing and wellness practices.

1.2 **Primary and Community Care:** Regional health authorities will implement an integrated, multidisciplinary primary and community care practice in each of the rural and small rural communities (based on population size it is recognized that certain rural communities may need more than one practice) that has:

• the capacity to address the episodic and longitudinal health care needs of the community/catchment area;
• the capacity to meet the needs of specialty populations (including maternity care, chronic medical conditions, frailty home support, cancer care, mental illness, substance use, and palliative care);
• for specialty populations, key service elements consistently applied across communities will include effective attachment and intake to the practice; assessment; case planning; case co-ordination; and rapid mobilization of services;
• services will include primary and community care; and
• the capacity to respond effectively to 24/7 urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.

This will be done in collaboration with physicians and through the vehicle of collaborative services committees to enable local community level partnerships between local health authority leadership, physicians, health professionals, patients, caregivers and community leaders to design integrated primary and community care practices across rural and small rural communities. Where practical, these will also act as the hub, outreach and support to remote rural community services.
The multidisciplinary team will be, where possible, co-located. Ideally, physicians will be fully incorporated into the teams but where this is not agreeable to existing physicians, they will be virtually linked with full incorporation being achieved gradually through replacement when they leave or retire or through the recruitment of new additional physicians to the community. The organizational delivery model can be health authority operated, provider-led by contract; or delivery through establishing a not-for-profit agency.

Where teams are located in a community with a hospital, the team will be fully linked into providing services in the hospital as appropriate.

The practice team will be augmented by visiting and virtual tele-health services with consultations for both patients and providers and where appropriate shared care between providers and specialists for patients.

Where appropriate, these teams will be built in partnership with the First Nations Health Authority and incorporate traditional models of wellness in primary, maternity and mental health services.

By Sept. 30, 2015, each of the regional health authorities will provide an assessment of the status of primary and community care services across all rural, small rural and remote communities and a specific three year plan on how they intend to move forward with this policy direction as a region. This plan will be referenced in their service plans, be available on the health authority website, and attached to their detailed service and operational working papers. It is recognized that this process will take time and engagement. The objective is for these services to be fully put in place over a three year period from April 1 2015/16 through Sept. 30, 2017/18 with subsequent continuous improvement and refinement. The regional health authorities will report out on progress against the plan to the Ministry of Health and on their website starting spring 2016.

2. Organizational Level – Operationally-Based Enabling Supports to Rural Health

2.1 Practice Support Teams: Regional health authorities in collaboration with other service partners will put in place designated practice support team(s) by June 30, 2015 to enable the implementation of integrated, multidisciplinary primary and community care practices across their rural and remote communities. The teams will support the establishing collaborative support committees and then support these committees and the providers through the
practice design and implementation phases of the work. These teams will also play a critical role in supporting the assignment and/or recruitment of health professionals to the practices as required.

2.2 **Home Support and Residential Care in Rural Communities:** In collaboration with communities and patients, regional health authorities will initiate work on exploring innovative and cost effective service options to better support aging in place but also clarity on residential care options for when they are required to allow active preplanning by older adults and their families. This work will be reported in their service plans, be available on the health authority website and attached to their detailed service and operational working papers starting 2015/16.

2.3 **Access to Specialist Consultation and Support:** The regional health authorities in collaboration with the Provincial Health Authority will establish a formal regional, and where appropriate, provincial network of specialized teams available by telephone, telepresence or visits with rapid mobilization capacity to support primary and community care practices across rural and remote communities. These networks will be established by the end of fiscal year 2015/16 and reported out in their service plans, be available on the health authority website and attached to their detailed service and operational working papers starting 2016/17.

2.4 **Emergency Health Services and Access to Higher Levels of Emergency Health Care:** BC Emergency Health Services (BCEHS) will conduct a comprehensive strategic and operational review of inter-facility patient transfers that occur by ground ambulance to improve emergency response capacity and ensure timely, quality pre-hospital care in rural and remote communities. The review will examine appropriate deployment of BC Ambulance Services (BCAS) transportation resources and be complete by October 2015 and reported to the Ministry of Health and be available on the BCEHS and regional health authority websites.

BCEHS will report out no later than October 2015 on its demand analysis and deployment modelling to ensure air ambulance resources and critical care paramedics are optimally located and deployed to deliver timely, quality patient care.

BCEHS in collaboration with the Ministry of Health will pursue changes to the regulatory framework and expand roles for paramedics to enable effective use of advance care paramedics in rural and small urban communities. This will be also linked to the introduction of a minimum of 80 new FTEs in community paramedicine at the primary care paramedic or advanced care paramedic level over the period April 1, 2015 to March 31, 2018.
2.5 **Rural Hospitals:** Regional health authorities on their websites will provide information for their communities on the range of hospitals available across their region, the level of care provided by those hospitals, pathways to accessing care at those hospitals linked to their primary and community care practices, and establish a rolling three year plan for those hospitals that gives clarity to patients and community around service directions. No later than April 2016/17, quality indicators will be routinely reported on hospitals through the Ministry of Health and on the regional health authority’s website.

3. **Provincial Level – System-Based Enabling Support**

3.1 **Health Human Resources Planning and Management:** A range of specific actions will be taken by the Ministry of Health to contribute to improved services for rural and remote communities:

- Develop and implement funding and compensation mechanisms to support health professional staffing models for the primary and community care practices in rural and remote communities, as well as the formal regional and where appropriate, provincial network of specialized teams. This will be done incrementally as the strategy is implemented in 2015/16 and be fully completed no later than March 2016 and be undertaken as appropriate in consultation with health authorities, the Doctors of BC and relevant unions.

- Optimize scope of practice, skill mix, and skill flexibility to support the rural primary and community care practice model. The Ministry of Health in consultation with the regional health authorities, colleges and associations actively review scope of practice linked to the enhancing generalist practice while utilizing specialist skills sets linked to each of the primary and community care health provider groups. As the models develop on the ground in the communities, the Ministry of Health will actively work to enable appropriate and safe changes in support of improved rural care.

- Work with the Doctors of BC, the Joint Standing Committee on Rural Issues, the Rural Coordination Centre of BC, the University of British Columbia Faculty of Medicine and Continuing Professional Development department and others, to better elaborate and support through training generalist models of physician practice in rural communities throughout the province.
• In 2015/16, complete a review and make recommendation for improvements and additions to incentive and support programs for health human resources in rural and remote communities linked to the evolving practice models. Specifically review and improve upon existing physician recruitment and retention incentive programs and supports by introducing more flexibility to better respond to community service needs, and implement a provincial Practice Ready Assessment program that will prepare internationally-educated physicians for practice in rural and remote settings in the province. Develop incentive programs and supports specifically for nursing and allied health care professionals to enable inter-professional models of care, and implement a provincial Nursing Community Assessment Service to enable internationally-educated registered nurses, licensed practical nurses and care aides to enter the workforce in our province. Work with other provinces and the federal government to address barriers to recruitment resulting from changes to the Temporary Foreign Worker program.

• Working with HEABC, the Ministry of Health will focus on improving timely recruitment and deployment of health professionals to rural and remote communities. The work will include developing an evidence-based and survey informed provincial forecast and resource planning model linked to regional and local resource plans for rural and remote communities to allow increased practice recruitment and deployment of health professionals in advance of retirements or leaving, including allowance for overlap and duplication of services over transition periods to increase continuity of service provision. The work will also include the development of a provincial approach to best practices in marketing and recruiting health professionals to work in rural and remote communities. Finally the work will also develop, in collaboration with regional health authorities, contingency service action plans for high risk communities with very small numbers of health professional staff to better mitigate service loss due to retirements or when staff leave to take other roles. The work and recommendations for action will be ready for deployment April 2016.

• In 2015/16, the Ministry of Health will review opportunities for expansion and distribution of education and training programs specifically for nursing and allied health care workers within Interior, Northern and Island health authorities, in order to support education and training of individuals closer to their own communities, and work with professional associations and unions, educators, health authorities and other partners to reach out to students in local communities to promote career opportunities in health care.
In 2015/16, the Ministry of Health will examine policy tools available for government and health authorities to have more effective influence on distribution of health care professionals throughout the province. This will include consultation with the Doctors of BC and health unions. Recommendations will be brought forward in the fall of 2015.

3.2 **Accountability and Implementation:** The Ministry of Health, through the Health Service Policy and Quality Assurance division, will establish public reporting, monitoring and impact/outcome assessment mechanisms for deployment starting April 2015.