Preface to the Ross Report:
*Review of the Role of Emergency Services at the Victorian Community Health Centre of Kaslo, BC*
Dr John Ross, August 2013

Dr. John Ross, a Nova Scotia physician, was engaged by Interior Health in the spring of 2013 to provide a review of emergency services in the Kaslo area. Dr. Ross was asked to participate in the community engagement process which took place in March and April 2013, to provide a report describing the current state of emergency services, and to offer recommendations for Interior Health’s consideration.

Interior Health would like to express appreciation to Dr. Ross for his perspective and considerations regarding the systems and processes involved in delivering emergency care in rural B.C.

Some of the suggestions in the Ross Report are already being acted upon. A more detailed response to the report’s recommendations is available on the following pages of this preface.

Based on analysis we have done, and the input we received during this spring’s consultation sessions, we believe Kaslo and area residents would best be served through stable and robust primary care services that meet their regular, ongoing health-care needs - ready access to physicians, mental health and public health nursing services. Adjusting emergency department hours will allow us to focus on primary care and make the best use of the resources we have available to us in Kaslo.

We thank the Kaslo and Area Health Care Work Group for their dedication to the consultation process, and we will work with them as our services transition.
Ross Report

The report contains 16 recommendations that can be grouped into five main themes:

1. Recruitment and Staffing
2. Management
3. Education
4. Transportation
5. VCHC clinic/ED

Recommendations and Interior Health’s responses are outlined below.

1/ **Recruitment and staffing**
   - Involve community members in staff interviews
   - Establish more full time positions and differentiate between ED and residential care staffing
   - Streamline physician contracts and paperwork
   - Explore physician payment mechanisms with the Ministry of Health (allow physicians to provide their own locum coverage and explore the cost/benefit of 3 FTE physician positions)

IH Responses:
   - While this is an interesting concept, privacy legislation and our collective agreements would likely make it unworkable to involve community members in staff interviews.
   - We will consider the number of full time positions and staff mix as work takes place on developing a sustainable service model for VCHC.
   - Streamlining contracts and paperwork largely relates to locums (temporary physicians), and we are open to explore ideas to streamline this process.
   - Physician locum support for rural communities is provided through the provincial Rural GP Locum Program that has been established and operated by the Joint Standing Committee on Rural Issues (JSC). The JSC is comprised of representatives from rural physicians; health authorities; the BC Medical Association and the Ministry of Health. We will bring the ideas being raised for locum physician coverage forward for considerations by the JSC.

2/ **Management**
   - Strengthen site leadership, develop co-management model with physicians

IH Response:
   - We are moving forward with this now. Reporting relationships at the site have been clarified, we’ve taken steps to improve communication with staff and physicians, and processes are underway to include physicians in management discussions.

3/ **Education**
   - Strengthen staff/physician competencies with simulation training, rural critical care course and acute shifts at Nelson and Trail hospitals
IH Response:
- The JSC sponsors a number of programs to support the continuing professional development of physicians practicing in rural communities like Kaslo, such as the Rural Continuing Professional Development (RCME) program and the Rural Education Action Plan (REAP). We will work with the JSC and with physicians working in Kaslo to obtain support available from these programs to support patient care.
- We are already working on a plan to do more HART outreach training in Kaslo and other rural sites in the Kootenay Boundary.
- As soon as we have a stable team of physicians in place we intend to offer a Care Course in Kaslo which will focus on team building and skills enhancement, specifically for people working in smaller rural EDs.

4/ Transportation
- Work with BCAS to improve emergency response and transfer through development of protocols and algorithms for time-sensitive but uncommon health problems
- Pursue creative staffing options with BCAS (such as Advance Care Attendant who would work in VCHC and support BCAS)

IH Responses:
- We will continue to work with BCAS, both locally and at the provincial level, to ensure residents have access to timely emergency transport with skilled paramedics and Interior Health’s High Acuity Response Team.
- Our focus at VCHC is developing a strong, robust primary care model that provides area residents with the consistent care they need on a regular basis. Once that is in place we can explore options such as introducing paramedic skills into the health sector. An initiative like this has the potential to attract and retain paramedics in rural communities and complement the multidisciplinary health care team.

5/ VCHC Clinic/Emergency Department
- ensure all health care professionals are working to their full potential
- reduce clinic hours for physician who is post call
- add Nurse Practitioner to support both primary care and ED
- explore potential for remote physician model to support 24/7 ED
- develop an accountability framework to assist in rural site management

IH Response:
- We are already working on some of these suggestions on our own; others are more complex and would require further discussion with partners such as the Ministry of Health and physicians.
- In B.C. Nurse Practitioners (NPs) receive education that prepares them to work in clinic settings, rather than in specialty areas such as emergency departments. NPs are also required to consult with or refer to physicians when a patient’s diagnosis and care is beyond their scope of practice. That means that a physician must be available to respond to an NP’s request for assistance with a complex patient issue.
• IH has NPs working in rural areas, in collaboration with physicians, and this is a model that can be effective in meeting the needs of those living in rural areas.

• The remote physician emergency model Dr. Ross references in Nova Scotia may not be applicable in B.C. Nova Scotia has a different legislative framework and different community needs.

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Review of the Role of Emergency Services at Victorian Community Health Centre of Kaslo, BC

Recommendations Based On A Focused Community Consultation and Personal Interviews March-April 2013

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Introduction

This report is a supplement to the work that has already been completed and beautifully summarized in the ‘Community Consultation Summary Report’ that has recently been circulated. As a brief introduction, I will review my involvement with this exciting project.

Due to frequent and unpredictable unscheduled service disruptions at the Victorian Community Health Centre (VCHC) in Kaslo, a result of both nursing and more recently, physician shortages, and following similar trends across Canada, it was reluctantly decided by the Interior Health Authority (IHA) to alter the hours of operation of the Health Centre, including a reduction in emergency services. The decision was not accepted by the community. The Kaslo and Area Health Care Work Group was established, intent on working with IHA to explore alternative solutions. Clearly there was considerable interest expressed by many members of the community, who wished to have input into future planning. It was decided that a community consultation process should occur, and a steering committee was established. The report The Patient Journey Through Emergency Care in Nova Scotia¹ was found that resonated with some of the steering group members, and I, as the author of that report, was invited by Dr. Alan Stewart to participate in the community consultation process and review the emergency services in the area.

Following phone calls, a presentation in Kelowna, and e-mails with steering group members, including the consultant facilitator and change expert Linda Tarrant, a very well organized community and health centre staff consultation process was completed. To obtain as full a picture of the situation in a short period of time, several members of the community at large were interviewed independently, including former and current Health Centre staff, BCAS/HART staff, and several local residents to get an ‘off-the-record’ perspective of the issues that were affecting the Health Centre and its role in the area. The Consultation Summary Report contains all the focus group and the April 22 planning day comments, suggestions, and recommendations for future development – that will not be repeated here. This document summarizes what I heard while in the Kaslo area, brings some experience from other jurisdictions, and offers some ideas to consider. As I am still a practicing Emergency Physician, an academic at Dalhousie University, and advisor to the Nova Scotia Department of Health and Wellness, I will confess relatively limited ‘consultant’ experience. Therefore this report will be direct, founded on observations, current and past experiences, and some literature research.

Summary of Recommendations

1. Recruitment: Consider collaborative recruitment of clinical staff and local management with active participation from community members. For example, community representative(s) (patient-centred) could join VCHC staff on interview/selection committees (note: this is already being done for physician applicants.)

2. Consideration could be given to a staffing model that includes more full-time and part-time positions than casual employees. The increased ‘up-front’ costs would need to be weighed against the potential gains in staffing stability, potential decreased over-time, and unplanned service interruptions. A commitment by IH should yield a return commitment by a more stable, local work force.

3. Consideration could be given to a staffing model that takes into account the different responsibilities of the Emergency and residential nursing care duties.

4. Emphasis should be placed on strengthening Health Centre leadership with a view to development of a co-management model, shared between non-physician and physician leaders.

5. Consideration should be given to rewording physician contracts to be less complicated while including performance criteria and performance deliverables. A focus should be on maximizing the attractiveness of a rural practice while minimizing MOH/IHA programs administration. This will also leave time for involvement in Health Centre leadership and co-management.

6. IH should facilitate processes that free physicians from the complex paperwork associated with some Ministry programs. The goal should be to maximize their strengths in clinical knowledge and skills while minimizing their relative weakness in following myriad program rules and processes.

7. IH should consider negotiating with the funder to enable physician self-locuming. As a patient-centred strategy, it would serve as an incentive for contracted physicians to spend more time in Kaslo that will enhance the continuity and permanence of the physician workforce. It would also make Ministry funding more effective while decreasing Health Centre staff time recruiting and supporting frequent locum coverage.

8. All clinical staff members require some critical care maintenance of competency. This is in addition to the more traditional education and conference leaves and home self-study. The following should be considered:
a. Provide regular on-site simulation based learning of uncommon but ‘need to know’ medical, surgical, obstetrical, pediatric and trauma cases. HART staff are apparently able to provide (some/all of) this.

b. Consider providing every one-two years the Rural Critical Care Course endorsed by the Society of Rural Physicians of Canada for rural sites in IHA (www.srpc.ca/rcc/index.html). There is a course provided in BC – the Comprehensive Approach to Rural Emergencies (CARE) (http://www.rccbc.ca/education/The_CARE_Course.) There is also a course, recently being used in Nova Scotia and New Brunswick, that has been provided in the USA for years – Rural Trauma Team Development Course (http://www.facs.org/trauma/rttdc/)

c. Consider including as part of front-line clinical staff schedules, three to five days every four to six months in an acute care setting in either Trail or Kelowna where there is at least double coverage. At acute care sites where there is more than one physician (or nurse) covering a shift, consider scheduling personnel from rural sites into the non-charge shift. This provides the opportunity to be part of the assessment and management of unstable patients with experienced full-time emergency personnel while working, and being paid for a scheduled and necessary shift.

9. Several options can be considered to maximize physician resource effectiveness:

a. Add a Nurse Practitioner (NP) to the Primary Health Care Clinic and reduce some of the physician time there. The role could be as a physician-extender. Depending on the individual, he/she may be able to participate in the on-call rotation.

b. Maintain the physician on-call schedule, but book only an afternoon clinic after the physician has been on-call the night before

c. Modify the need for on-site physician availability ‘after hours.’ Create a nurse, nurse; nurse, NP; nurse, paramedic late evening/night emergency care service. An oversight physician could be available at another IHA site, or virtually anywhere. This is currently being done in Nova Scotia (RN-Paramedic and RN-RN) and is about to be implemented in PEI. The physician oversight role could be similar to or even added to the current IH Transport Advisor role. It would require specific protocols and training. A Nurse Practitioner – remote Emergency Physician system has been in place in rural Mississippi since 2003 with considerable success and cost effectiveness.²

d. A new role, the Advanced Care Attendant (ACA – a BLS trained paramedic with enhanced patient care skills) has been discussed between IHA and BCAS. An ACA, with adequate training, could be teamed with an RN and on-line physician to provide night coverage. The above suggestions are new and untried in BC, but traditional roles need to be challenged. Using patient needs as the lens and not what a discipline is willing to provide can help produce different health human resource roles and responsibilities.

10. Consistent with the ‘Patient-Centred’ lens, consideration could be given to augmenting the roles of the other regulated health professionals who are currently available in Kaslo. More regular community consultations, identifying real and perceived needs will help identify what services and providers are needed.

11. Have regular health care provider meetings where each discipline spends a few minutes educating others about their role in the community, changes in their profession, and other roles they could provide.

12. IHA and BCAS personnel have developed an excellent collaborative relationship. Continuing to identify and address the system demands and supply challenges are key to having a seamless emergency response and transfer system. In the rural setting, it will be vital to continue paramedic staff development and sharing of ‘multi-task worker’ staff, such as the Advanced Care Attendant, in the ambulance as well as in the Health Centre. Rural centres need to explore more creative staffing models to leverage the skills and knowledge of the health care providers in the area. It also helps to maintain skills. IH and BCAS should continue to collaborate on the development of easy to follow emergency care protocols and algorithms for time-sensitive but uncommon health problems.

13. Follow-up on arranging HART site-based refresher training for all appropriate staff. Develop a curriculum and arrange regular sessions.

14. Explore opportunities offered by the Vancouver Foundation for paramedic development as an innovative community project.

15. Skills enhancement/maintenance - Develop a relationship with the Emergency Departments in Nelson and Trail that will enable regular shifts to be covered by nurses and physicians whose primary site is in Kaslo (or other small rural sites), ideally in a double coverage arrangement, to maintain emergency assessment and treatment knowledge and skills.

16. Consider creating an explicit, simple accountability framework for managing and reporting the multiple services, roles, and expectations of the rural VCHC site and others like it.
Review of Victorian Community Health Centre of Kaslo

VCHC of Kaslo has all the basic ingredients to be a very successful centre. It is located in a beautiful part of southeastern BC, one hour north of Nelson that has a well equipped hospital, and approximately two hours to a full-service regional hospital in Trail. It has a well educated, engaged community which is active and relatively free of addictions and chronic social problems that plague some more remote communities. The Health Centre is centrally located, well designed and highly functional. The current issues are not complex historical/cultural problems nor is there a need for capital intensive renovation/rebuilding. Problems relate mostly to process, staffing, communication, relationships, organization, and innovation challenges. These can all be addressed and resolved.

Definitions

‘Primary care’ is used frequently by people, but in many different ways. Primary care is more about the first point of contact (Family Practice Clinic, Emergency Department) whereas Primary Health Care is more about a system that is designed to keep people healthy and provide for those who are not. For purposes of this report, both definitions will be used:

**Primary Care** – the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community (Institute of Medicine Committee on the Future of Primary Care, 1996)

**Primary Health Care** – Primary Health Care is defined as a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services (Canadian Health Services Research Foundation, 2003)

**Emergency Care** – The screening, examination, and evaluation by a clinician to determine if an emergency medical condition exists, and if it does, the necessary care to relieve the emergency medical condition, within the service capacity of that hospital/health centre, or the safe and timely transfer to another facility.

**Health Care – People Helping People**

The health care ‘system’ has evolved in response to the need to deliver relatively uniform care to a diverse, geographically distributed group of people. Although it is delivered by provider professionals, managers and administrators, we must not forget that it exists first and foremost for people, paid for by tax-payers, and must remain people focused and centred. In a rural setting, this is of critical importance.

The health care system is basically about people helping people. It is about relationships. There is a considerable body of literature about the importance of effective personal and professional relationships. One article in the Family Practice Management
Journal\textsuperscript{3} summarizes nicely seven characteristics of successful work relationships. One can consider these on different relationship levels: patient-health care provider; between professional colleagues (intra- and interdisciplinary); front-line providers and management; health centre and local government; between health centre sites in a district; sites and health authority; other entities such as BCAS and HART. All these relationships require ongoing work to establish, grow, and maintain.

1. **Trust**: This is a foundation principle. It also encourages all disciplines to work to their scopes of practice. It is vital at all relationship levels.
2. **Diversity**: Differences in the way people view the world.
3. **Mindfulness**: People are open to new ideas; ideas can be expressed without criticism or punishment; continuous quality and process improvement is a way of life.
4. **Interrelatedness**: People understand how their work relates to and affects others. They understand their part in contributing to a larger goal. People with this quality can respond to unexpected challenges more effectively.
5. **Respect**: This is vital in a setting with many moving parts, where opinions are valued, where regular problem solving is needed, and give and take is necessary.
6. **Varied Interaction**: Relationship building and maintenance needs to occur both inside and outside the workplace. Getting to know, work, and play with people one interacts with regularly builds more sustainable relationships.
7. **Effective Communication**: The other foundational principle. Knowing when and how to communicate in person or telephone (multi-channel communication – complicated or sensitive issues where immediate two-way expression, facial and body language is needed) versus using e-mail (single channel – short messages, not controversial, FYI only)

If one word was needed to identify where energy should be focused to address the health care needs of the Kaslo community, it would be re-establishing and building RELATIONSHIPS.

\textsuperscript{3} Tallia AF, Lanham HJ, McDaniel RR, Crabtree BF. 7 Characteristics of Successful Work Relationships. 2008. www.aafp.org/fpm (accessed 06/04/13)
The Interior Health Charting the Course document, the summary Strategy Map (above) and the innovation project at the Kaslo Victorian Community Health Centre are well aligned. Using the map to navigate the proposed changes and ensure consistency with the overall vision and specific goals is a useful check for consistency. It is a very well done, visually accessible, easy to follow, and a well principled document.

**Findings and Recommendations**

**24/7 Emergency Department**

This was a very common thread and came up, one way or another during the discussion of most questions. Before discussing staffing challenges, potential solutions and recommendations, a review of recent data will be helpful.

During the period April 1 2012-13 there were 950 patients registered in the Emergency Department or 2.6 per day on average (consistent with the previous year visits of approximately 1000.) 83% were treated and returned home. 15% were sent to Nelson, Trail, or Kelowna. There were two deaths.

CTAS 1 are life or limb threatening and require immediate attention (unconscious, multi-trauma, very abnormal vital signs); CTAS 2 are somewhat unstable and require attention in <15 minutes (chest pain, stroke, shortness of breath, severe pain, suicidal); CTAS 3 are stable but require initial assessment in 30 minutes (abdominal pain, headache, weakness, dehydration, depression); CTAS 4 most injuries, stable medical problems
should be seen in < 1 hour; CTAS 5 least acute, minor injuries, viral illness with normal vital signs should be seen in < 2 hours.

<table>
<thead>
<tr>
<th>ED Visits</th>
<th>Time of Day</th>
<th>Age Range</th>
<th># in Age Group</th>
<th>CTAS</th>
<th># in each Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 (7%)</td>
<td>0000-0759</td>
<td>&lt; 17</td>
<td>168</td>
<td>1</td>
<td>8 (0.8%)</td>
</tr>
<tr>
<td>304 (32%)</td>
<td>0800-1159</td>
<td>17-35</td>
<td>151</td>
<td>2</td>
<td>70 (7%)</td>
</tr>
<tr>
<td>285 (30%)</td>
<td>1200-1559</td>
<td>36-55</td>
<td>205</td>
<td>3</td>
<td>311 (33%)</td>
</tr>
<tr>
<td>195 (20.5%)</td>
<td>1600-1959</td>
<td>56-75</td>
<td>296</td>
<td>4</td>
<td>405 (43%)</td>
</tr>
<tr>
<td>90 (9.5%)</td>
<td>2000-2359</td>
<td>&gt; 76</td>
<td>130</td>
<td>5</td>
<td>147 (16%)</td>
</tr>
</tbody>
</table>

During an audit of the CTAS 1, several were misclassified and should be CTAS 2 or 3. The same is true of the CTAS 2 and 3 patients. ‘Over triage’ commonly occurs when the CTAS system is not frequently used – regular audits are helpful to maintain triage scoring skills. It is quite likely therefore that the number of CTAS 1, 2 and 3 are over-represented and the CTAs 4, 5 under-represented.

141 patients were transferred to another hospital, 60 of them were initially triaged by VCHC staff as CTAS 1 or 2. A review of those 60 transfers follows:

- 20 chest pain or dysrhythmia – rule out cardiac cause (note several patients were transferred multiple times)
- 12 multi-system or isolated head or limb trauma
- 9 shortness of breath (chronic obstructive lung disease, pneumonia, asthma, heart failure)
- 3 mental health or substance misuse
- 3 dislocated or fracture hip
- 1 pregnancy issue
- miscellaneous medical or surgical issues

Despite the low ED visits, the geographic location of Kaslo, road conditions, and variable weather, as well as distributed population in Johnson’s Landing, Argenta, Meadow Creek and area support the need for a 24/7 facility available for emergency visits. The limitations of the facility must also be acknowledged. As an example, time and experience sensitive conditions such as multi-system trauma, stroke, and myocardial infarction, are often managed by integrated health care systems to minimize time to definitive care. There are times when bypassing VCHC en route to Nelson, Trail, or Kelowna, and scene activation of HART or helicopter is in the best interest of the patient.

However, even though less than 8% of the emergency visits to VCHC are higher acuity patients that may require familiarity with stabilization, resuscitation or trauma knowledge and skills, there will always be a need for regular practice of such skills and knowledge in a team setting (see below.)
In Nova Scotia, rural hospital EDs also have relatively low visit numbers and low severity scores. An example follows:

<table>
<thead>
<tr>
<th>Shift</th>
<th>Regional</th>
<th>Community</th>
<th>Small Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800-2000</td>
<td>55.5 pt per day</td>
<td>34.9 pt per day</td>
<td>27.4 pt per day</td>
</tr>
<tr>
<td>2000-2359</td>
<td>13.7</td>
<td>6.9</td>
<td>2.5</td>
</tr>
<tr>
<td>0000-0800</td>
<td>10.3</td>
<td>4.4</td>
<td>1.3</td>
</tr>
</tbody>
</table>

CTAS

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>0.2%</td>
<td>7.3%</td>
<td>27%</td>
<td>43.4%</td>
<td>17.1%</td>
</tr>
<tr>
<td>II</td>
<td>0.1%</td>
<td>1.3%</td>
<td>18.4%</td>
<td>53.1%</td>
<td>27.1%</td>
</tr>
<tr>
<td>III</td>
<td></td>
<td>10.4%</td>
<td></td>
<td>32.5%</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td></td>
<td></td>
<td>54.2%</td>
<td></td>
</tr>
</tbody>
</table>

Admit or Transfer

|   | 7.2% | 4.3% | 4.9% |

Data from the review of the North-West LIHN in Ontario shows a similar distribution, and essentially the same graphs for all the rural facilities in that area.

This data supports that many rural EDs are being used for the assessment and treatment of problems that could be seen in another setting (clinic) and in most cases, could safely wait until clinic hours. For isolated communities, 24/7 emergency access could be provided by an experienced, well-trained non-physician, with physician consultation available by phone or teleconference, appropriate bypass protocols, and occasional emergency transfer to another site when needed (see transport section below.)

A new staffing model was introduced in Nova Scotia in 2011 as part of Better Care Sooner. It uses a Primary Care Paramedic and Nurse, Advanced Care Paramedic and
Nurse, or Nurse-Nurse staffing the after-hours (usually 2000-0800) clinic/emergency area (called the Collaborative Emergency Centre - CEC in Nova Scotia.) All patients are first assessed by the non-physician team, and then a call is made, through a central communications centre (that also manages all provincial ambulance and trauma program calls), to the CEC on-call Emergency Physician. Together the three health care providers determine a safe management plan for the patient that will result in treatment, no follow-up required; temporary treatment and book follow-up for later or the next day; transfer to another centre.

It is still early, but closures of formerly chronically closing facilities have been reduced dramatically. Furthermore, patients now have far better access to primary health care as the clinic is staffed by a Family Physician more often.

Comparison of 6 newly converted CEC: closure hours before and after

Comparison of 6 newly converted CEC: closure hours before and after

Typical of all seven currently operating CECs in Nova Scotia
(34% treat, no follow-up needed; 50% treat and arrange follow-up; 16% transfer)
Kaslo Victorian Community Health Centre Staffing

Although other process and policy issues have been identified, consistent and predictable Health Centre staffing is the number one issue and has been the reason for service interruptions. It is of course complicated. The hospital/Health Centre has evolved from local management by a 12 person Board and Village Council, with liaison in Nelson, local nurses, and one 24/7 doctor to a Regional Health Authority administered in Kelowna, centrally unionized nurses, many of whom come from outside Kaslo, and contracted part-time and locum doctors.

As mentioned at the outset of this report, the seven dimensions of a healthy working relationship, if created and supported at the Health Centre, may improve inter-professional collaboration, team work, efficiency, work place satisfaction and therefore positively impact the patient care experience and clinical outcomes.

Nursing Issues

- Most nursing contracts are ‘casual’:
  - Employer Benefit
    - More employer flexibility and casual employees do not receive benefits
  - Employee Benefit
    - Flexible hours and choice of work sites

- Commonly Identified Problems
  - Lack of job security for the employee
  - Less commitment to the site – casual employees are mobile
  - Difficulty filling shifts as many casuals are not local residents
  - Increased cost of overtime
  - Increased orientation time/cost
  - Frequent turn-over results in staff less familiar with each other and local processes, limiting individuals to work to their full scope of practice due to uncertainty and lack of trust
  - Inability to create a ‘health care team’ as members keep changing – hard to establish clinical trust relationships between nurses, between other professionals, and with patients which may also impact efficiency and patient satisfaction
  - Casual employees find it difficult to obtain a mortgage from the bank when considering a move to Kaslo – another disincentive to making a commitment to the community
  - Similar issues were raised in the excellent review by KPMG of the North-West LIHN in Ontario. They noted numerous nursing vacancies and concluded, “these vacancies were primarily part-time positions. Communities found it difficult to attract new individuals to communities with part-time work.”

Note: Common definitions found in BC health workforce collective agreements are as follows:

**Full-time** – Regular full-time employees are those who are scheduled to work the hours of work and shift patterns laid out in the agreement – usually 35-hour weeks excluding meal periods and inclusive of rest periods. Regular full-time employees accumulate seniority and are entitled to all benefits.

**Part-time** – Regular part-time employees are those who are regularly scheduled to work a minimum of fifteen (15) hours or equivalent per week, but less than the full-time hours in the agreement. Part-time employees accumulate seniority and benefits proportionate to hours worked except medical, extended health, dental, LTD, and group life insurance premiums, which are paid the same as full-time employees.

**Casual** – Casual employees are those hired on an as-and-when-needed basis. Pay is based on experience. Seniority is based on accumulated hours worked. Casual employment may have specific exemptions regarding wages, premiums, and benefits. Overtime work must be given to regular full and part-time employees first.

- The unique professional attributes required of a nurse working in a relatively remote setting are special. The Health Centre with community input should interview and select staff who members are most appropriate for the setting.

- Maintenance of competency in rarely required but ‘must have’ skills and knowledge such as recognizing and managing acute MI, stroke, anaphylaxis, seizure, cardiac arrest, trauma is not regularly provided and is therefore either not done or must be found elsewhere. In small Emergency Departments, it is often a cause of professional anxiety as public expectations of expertise and proficiency may be difficult to meet.

- Nurses are therefore difficult to find, resulting in frequent staffing crises and predictable but ‘unexpected’ closures (one can predict there will be staffing gaps, but the timing is unexpected each time)

- During the consultation process, residents and staff claimed that there are nurses who are interested in working more at the Health Centre and area

- Apparently there is/was a Nurse Practitioner (NP) interested in working in Kaslo. The role of a NP in the area should be considered in the context of the current and future needs of the community and the current health human resources in Kaslo.

- It was difficult to understand after only a few days in Kaslo, but Health Centre nurses are required for multiple roles, the top three being Primary, Continuing,
and Emergency Care. Although all are different, the role of inpatient chronic and palliative care requires a unique perspective and skill set that is very different from Primary/Emergency Care.

Other Clinical Staffing Opportunity

- There has been some discussion between BCAS and IHA since 2008 of developing an Advanced Care Attendant at VCHC. Kelowna General Hospital has established the hybrid role of community primary care paramedic and hospital-based clinical assistant. It would need to be modified to fit the multi-task needs of a rural facility and ambulance service. Nova Scotia has leveraged the basic knowledge, skills and attitudes that paramedics have and created a variety of different, key roles in the primary and emergency care settings (in essence like taking a standard car chassis and adding different features to meet the clinical requirements:
  - Standard Primary Care, Advanced Care, and Critical Care paramedics (National Occupational Competency Profiles well described at http://paramedic.ca/nocp/)
  - Novel Triage Paramedics at several sites (instead of nurse triage)
  - In ED critical care, airway, and procedural sedation paramedics (Halifax Infirmary)
  - Fast Track paramedics (Halifax Infirmary)
  - Community paramedics – provide care in nursing homes in collaboration with nursing and Family Physician – alternative to ED visits
  - Collaborative Emergency Centres (CEC) – provide 8 pm- 8 am emergency care service in collaboration with an on-site nurse and on-line (telephone) Emergency Physician

- The preceding list is an example of innovative use of a ‘multi-task provider’ whose role is designed in response to the needs of the patients in the community and not discipline limited

- I strongly support the Advanced Care Attendant role, but suggest consider revisiting the job description and which health care providers would be considered for advanced training to meet the broad requirements of the role. Addressing present and future clinical needs at the Health Centre, making the role attractive and rewarding, and being flexible regarding episodic ambulance calls will be really important. Furthermore, this new role will require a manager that really understands both the out-of-hospital environment as well as Health Centre needs.

Site Management

- Site management, currently provided by Nursing, is often consumed with the daily crises of staffing, physician shortages, locum management, and quality issues. That leaves little or no time (or energy) for addressing and proactively planning the broad demands of a constantly changing workforce and geographically challenging population that requires care.
Site management has not received the training or support to be effective

- There is no site-based physician leadership and limited physician engagement in the day-to-day management of the Health Centre
- Stress within and between professional, administrative and support disciplines can result when leadership is occupied with day-to-day minor and major crises and unable to adequately consider functional, proactive, forward planning.

**Recommendations**

1. Consideration could be given to a staffing model that includes more full-time and part-time positions than casual employees. The increased ‘up-front’ costs would need to be weighed against the potential gains in staffing stability, potential decreased over-time, and unplanned service interruptions. A commitment by IH should yield a return commitment by a more stable, local work force.

2. Consideration could be given to a staffing model that takes into account the different responsibilities of the Emergency and residential nursing care duties.

3. Emphasis should be placed on strengthening Health Centre leadership with a view to development of a co-management model, shared between non-physician and physician leaders.

**Physician Issues**

**Remuneration**

Physicians in Kaslo are contracted by the Health Authority. By way of background, through negotiations with the Provincial Ministry of Health and the BC Medical Association, specific funding models have been derived for small communities that are different than the usual fee-for-service approach (i.e. where physician income is derived from billing the MSP for items of service). These models are referred to as Alternate Payment Plans (APP) where funds are provided to the Health Authority to pay physicians directly. A contractual arrangement outlines mutual expectations regarding the quantity and nature of the work to be performed and the compensation to be provided. The word “Alternate” is used to differentiate this form of payment from the usual means by which physicians in BC earn their income i.e. fee-for-service (FFS). Communities are identified as requiring an APP where the volume of work is considered insufficient to provide enough FFS income to recruit and/or retain Family Physicians. Kaslo has funding for two fulltime equivalent Family Physicians (2.0 FTE’s).

In addition to the compensation for physician services, rural physicians receive a number of other benefits through a variety of programs sponsored by the MOH and BCMA through the Joint Standing Committee on Rural Issues (JSC). Based on a recent report “There is a suite of nine programs primarily addresses financial incentives and compensation. Five provide financial benefits and four have both financial and non-financial benefits. The five current programs with principally financial benefits are:
The Rural Retention Program which provides fee premiums and flat fee financial benefits; (2) The Isolation Allowance Fund which provides stipend benefit for physician residing in small communities; (3) The Northern and Isolation Travel Assistance Outreach Program which provides funding to assist Health Authorities in providing outreach services; (4) The Recruitment Incentive Program which provides financial incentive for new physicians; and (5) The Recruitment Contingency Fund which assists RSA communities with recruiting expenses where the difficulty in recruiting is severe. The four other programs impact both financial and non-financial factors: (6) The Rural Continuing Medical Education which provides financial support for educational opportunities, to support the broad base of clinical skills required from rural physicians, improving career satisfaction and quality of care; (7) The Rural Education Action Plan which supports advanced skills training for physicians in rural practice, provides undergrad medical students with rural practice experience, and increases rural physician participation into the medical school selection process; (8) The Rural GP and (9) Rural Specialist Locum programs which help GPs and specialists secure subsidized periods of leave from practice, positively impacting work life balance, lifestyle and family priorities.


The programs described above, individually may help to address the challenging components of rural physician services in BC. However, they are very provider-centric and centrally administered by different MOH divisions and departments. Individually they may be well intentioned, but collectively they are difficult to navigate and may not provide the flexibility that each unique rural community requires and deserves. Despite the strengths noted above, the following observations are made based on interviews with physicians:

- The contracts appear to the physicians to be very detailed, proscriptive, and complicated. Some of this may be due to the logistics involved in having several different Ministry of Health and IHA programs that support physician benefits and services.
- A part-time contract caps the number of paid hours. Call-back hours consume contract hours and force the need to find, move, house, and pay separately a locum physician. Part-time physicians cannot stay in town and be their own locums.
- Detailed deliverables may contribute to a loss of the scheduling flexibility that is needed in a small rural site.
- Physicians are contracted employees instead of flexible medical generalist professionals who could be more committed to the region.
- The 7 qualities of professional relationships (as listed in the preamble) are potentially lost and the natural leadership role of the physician is not fully realized.

According to three physicians I spoke with, overall annual compensation is not an issue – it is felt to be adequate.

- The MOH formula, apparently based on the population catchment area for the Health Centre determined that 2 Full Time Equivalent (FTE) physicians can be funded. People interviewed did not know what the formula is or how it is applied.
Practically that means a permanent every other night call system. Currently no doctors have committed full-time – all are either locum or part-time. There was some consideration for four half-time physicians improving the on-call coverage, but that would require detailed scheduling to ensure, at best, the same every other night on call as there can only be two physicians in town while two will be away. This highlights the problem of applying a formula to a medical ecosystem. A one-in-two call schedule is not sustainable. Nor does it encourage evening or weekend clinics.

- I appreciate the following will be considered overly simplistic. It appears, without a full understanding of the nuances of the above programs that are used to fund physicians working in Kaslo, that the total money spent on part-time and locum physicians, including managing incoming locums, travel, lodging, etc. may be equal to or close to funding three FTE. If the money used currently in this way could somehow be reallocated, it would potentially provide for a more sustainable care model. From a physician point of view, the call schedule would be significantly improved, while preserving opportunities for vacation, study leave, etc. Other Health Centre staff I suspect would prefer working with well-known colleagues, rather than casual locums, and patients would have the more desirable provider continuity that came up frequently during focus groups.

**Skill Maintenance; Work/Life Balance**

- Maintenance of competency in rarely required but ‘must have’ skills and knowledge is not included in the contract and therefore must be obtained elsewhere.

- Being a physician in a relatively remote area requires unique skills, knowledge, and attitude. When there are staffing shortages, filling a schedule can be more important than matching the right person for the role. Once again, it is difficult to develop and maintain relationships with other staff and with patients/families with temporary physicians.

- A health human resource study listed the negative aspects of rural medical practice most often mentioned: professional isolation, long work hours, frequent on-call, burnout, lack of opportunities for professional development, and isolation felt by spouse and family. However, if recognized, these can be addressed by innovative scheduling and the use of developing technologies.

- Doctors are not known for legible writing, detailed record keeping, or excellent communication. With frequent physician turn-over, clear, accessible health records are important. Physicians also have unique approaches to gathering data, reaching provisional diagnoses, and ordering tests. If there is constant physician turn-over, following patients’ chronic diseases or identifying new problems and ensuring follow-up is very difficult. Laboratory tests, diagnostic imaging results and specialist consult follow-up can be a problem. Temporary

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physicians must review, sometimes in considerable detail, the logic the previous doctor was following, in order to act on new information. They may or may not follow a similar logic. This is time consuming, inefficient in terms of time taken away from active patient care, and risks patient safety if it is not done.

- What is the opportunity to work out a collaborative working relationship with a Nurse Practitioner in the Primary Care and/or Emergency Care settings? The role could be complementary to the physician clinic or provide out of town clinics and some house calls.

- Providing timely inter-professional, collaborative Primary Health Care access (same day, next day, two day) in addition to regular booked follow-ups is ideal in all settings. This is a priority and promotes true health care for the community. Remote communities also need timely, accessible, experienced emergency care for unpredictable injury or illness. While it is easier to cross-cover a Primary Health Care clinic and emergency care area during the day when there are multiple staff, being on-call every other night with a fully booked clinic the next day is not sustainable. As an example, two physicians working in the clinic and providing emergency coverage every other night and every other weekend, if the clinic opened at 0800 and ended at 1600 would be in the clinic or on call for 136 of the 168 hours in a week. Furthermore, there may be an opportunity to include a Nurse Practitioner in the call rotation, with clear indications of clinical responsibilities.

Recommendations

4. Recruitment: Consider collaborative recruitment of clinical staff and local management with active participation from community members. For example, community representative(s) (patient-centred) could join VCHC staff on interview/selection committees (note: this is already being done for physician applicants.)

5. Consideration should be given to rewording physician contracts to be less complicated while including performance criteria and performance deliverables. A focus should be on maximizing the attractiveness of a rural practice while minimizing MOH/IHA programs administration. This will also leave time for involvement in Health Centre leadership and co-management.

6. IH should facilitate processes that free physicians from the complex paperwork associated with some Ministry programs. The goal should be to maximize their strengths in clinical knowledge and skills while minimizing their relative weakness in following myriad program rules and processes.

7. IH should consider negotiating with the funder to enable physician self-locuming. As a patient-centred strategy, it would serve as an incentive for contracted physicians to spend more time in Kaslo that will enhance the continuity and permanence of the physician workforce. It would also make Ministry funding more effective while decreasing Health Centre staff time recruiting and supporting frequent locum coverage.
8. All clinical staff members require some critical care maintenance of competency. This is in addition to the more traditional education and conference leaves and home self-study. The following should be considered:

d. Provide regular on-site simulation based learning of uncommon but ‘need to know’ medical, surgical, obstetrical, pediatric and trauma cases. HART staff are apparently able to provide (some/all of) this.

e. Consider providing every one-two years the Rural Critical Care Course endorsed by the Society of Rural Physicians of Canada for rural sites in IHA (www.srpc.ca/rcc/index.html). There is a course provided in BC – the Comprehensive Approach to Rural Emergencies (CARE) (http://www.rccbc.ca/education/The_CARE_Course). There is also a course, recently being used in Nova Scotia and New Brunswick, that has been provided in the USA for years – Rural Trauma Team Development Course (http://www.facs.org/trauma/rttdc/)

f. Consider including as part of front-line clinical staff schedules, three to five days every four to six months in an acute care setting in either Trail or Kelowna where there is at least double coverage. At acute care sites where there is more than one physician (or nurse) covering a shift, consider scheduling personnel from rural sites into the non-charge shift. This provides the opportunity to be part of the assessment and management of unstable patients with experienced full-time emergency personnel while working, and being paid for a scheduled and necessary shift.

9. Several options can be considered to maximize physician resource effectiveness:

e. Add a Nurse Practitioner (NP) to the Primary Health Care Clinic and reduce some of the physician time there. The role could be as a physician-extender. Depending on the individual, he/she may be able to participate in the on-call rotation.

f. Maintain the physician on-call schedule, but book only an afternoon clinic after the physician has been on-call the night before

g. Modify the need for on-site physician availability ‘after hours.’ Create a nurse, nurse; nurse, NP; nurse, paramedic late evening/night emergency care service. An oversight physician could be available at another IHA site, or virtually anywhere. This is currently being done in Nova Scotia (RN-Paramedic and RN-RN) and is about to be implemented in PEI. The physician oversight role could be similar to or even added to the current IH Transport Advisor role. It would require specific protocols and training. A Nurse Practitioner – remote
Emergency Physician system has been in place in rural Mississippi since 2003 with considerable success and cost effectiveness.\textsuperscript{6}

h. A new role, the Advanced Care Attendant (ACA – a BLS trained paramedic with enhanced patient care skills) has been discussed between IHA and BCAS. An ACA, with adequate training, could be teamed with an RN and on-line physician to provide night coverage. The above suggestions are new and untried in BC, but traditional roles need to be challenged. Using patient needs as the lens and not what a discipline is willing to provide can help produce different health human resource roles and responsibilities.

Other Staffing Issues

There was not a mandate or time to go into other staffing issues other than those that affected physicians and nurses. However, from the perspective of the patient journey through the Health Centre, there were many comments about the unreceptiveness of staff to inquiries or feedback. This may be, at least partially, a symptom of the current uncertainty at the Centre. However, it has an impact on patient satisfaction. An equivalent of ‘Customer Service’ education for all staff, especially in reception, the first point of contact, would be a good team building exercise and could positively impact patient care.

Focus on Primary HEALTH Care Staffing

Although this review was precipitated by the community’s desire to maintain ‘24/7 ER’, as in other rural communities, demand for emergency services is reduced when there is improved access to predictable primary health care. Multi-disciplinary, organized, balanced (focus on immediate problems but also on prevention and health promotion), sustained Primary Health Care delivery should be the ideal for rural Health Centres, like the VCHC in Kaslo. The 12 social determinants of health are clearly demonstrated in such settings:

1. Income and social status
2. Social support networks
3. Education and literacy
4. Employment/working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetics
10. Health Services (this is what we call Health Care!!)
11. Gender
12. Culture

The Public Health Nurse, with home visits that help identify many of the above factors, and early interventions in schools, is a key part of effective primary health care and should have a prominent role in the community. In addition, considering the listed determinants, some clinicians in Kaslo felt that a dedicated Social Worker could add considerably to the collaborative model of care.

The BC Healthy Communities projects should be a core part of the Health Centre’s deliverables, engaging the public in regarding Primary Health Care not as a reactive problem-based issue but as a lifelong strategy. All Health Centre staff should be knowledgeable about the roles and programs that are available.

The community Pharmacist may be able to play a greater role in providing education, advice, and prescription renewals. There is a new Acupuncturist in town – non-medical practitioner roles should be considered in a small town setting. How is the Physiotherapist or Occupational Therapist role used? Dietitian? Addictions counselling? When there are limited clinicians available, multi-tasking, finding collaborative scope of practice sharing, and regular communication is vital. Competition, although healthy in business, is less desirable in a setting where demand outstrips knowledgeable care providers. Although these services are not covered by medicare, there may be many opportunities to mix public and private services in this setting.

It is also important for professional health care providers to recognize the many caregivers in the community who are helping keep people in their homes, provide transport, and provide continuity of care. There are spouses, relatives, and friends who care for people in their homes. But there are also people who live alone, who might, for a small incentive, provide some home care temporarily or long term. Keeping people in their homes is both people-centric but also fiscally desirable.

Recommendations

10. Consistent with the ‘Patient-Centred’ lens, consideration could be given to augmenting the roles of the other regulated health professionals who are currently available in Kaslo. More regular community consultations, identifying real and perceived needs will help identify what services and providers are needed.

11. Have regular health care provider meetings where each discipline spends a few minutes educating others about their role in the community, changes in their profession, and other roles they could provide.

Transportation

A meeting was held in Nelson after the first round of community focus groups. The following were able to attend:

Chris Mason - BCAS Superintendent
Dr. Jeff Hussey – HART Site Medical Director, IH Transport Advisor, and BCAS Medical Director, Trail
The meeting was very helpful in terms of establishing the current state of emergency response and inter-facility transportation. Weather, road conditions, and distance are all significant factors. In addition, the different levels of training and clinical practice of paramedics in rural BC provide challenges. There is one Advanced Care Paramedic (two years of training and some advanced skills) stationed in Trail, whereas the others are Primary Care Paramedics (one year or less of training.) There are some ‘driver only’ paramedics. Of the 145 paramedics in Interior BC, only 14 are full-time.

The transport challenges mentioned above – weather, roads and distances – in addition to the basic training of most paramedics in the Interior BC region makes true system design and operation difficult. A well functioning emergency health care ‘system’ is like the circulation heart, arteries and veins of an animal. Ambulance transport (air, ground, emergency/routine transfer) is like the blood. An effective, interconnected ‘system’ is highly dependent on a responsive, out-of-hospital transport system to hold it all together.

The HART program is composed of Critical Care Nurses and Respiratory Therapists who are added to a paramedic crew and can respond, from Trail, to Kaslo and region as needed. They are supported by an on-line Emergency or Critical Care Physician via telephone or radio. It is essentially impossible to provide immediate critical care transport to rural areas when the day-to-day need is very low. System designers must balance all the factors including distance, roads or flying conditions, weather, critical care skill maintenance, and cost. There will always be a compromise between expectations in an emergency and supply of appropriate personnel and equipment. The current arrangement is a very reasonable compromise.

IH and BCAS leaders should continue to jointly develop clear, easy to follow protocols that can expedite the delivery of emergency care, despite being uncommonly required. It is because it is uncommon that easy to follow algorithms are necessary. Some examples are:

- A hospital bypass protocol for major trauma patients in the Kootenay Boundary corridor
- Early and rapid deployment of helicopter or HART

In addition to traditional emergency patient stabilization and transport, another very valuable resource is HART members can provide some on-site advanced training from time to time. This was felt by all to be a needed service for more isolated sites. There would be significant value in getting regular site-based inter-professional emergency care training/refreshers. This can help to provide better care on-site or during local ambulance transport while waiting for HART to arrive at VCHC or intercept on the highway.
There was a feeling from some that the Vancouver Foundation may be a good source of support for local paramedic advanced training to support the ACA-like role and create practitioners that could meet the needs of the Health Centre and out-of-hospital skill/knowledge requirements. The Vancouver Foundation excerpt of their principles follows:

“At Vancouver Foundation we are passionate about community. Everything we do is designed to help build more vibrant, healthy and resilient communities across B.C.
We accomplish our work by harnessing the gifts of energy, ideas, time, and money of caring residents to make meaningful and lasting impacts. We are Canada’s largest community foundation and we’ve been investing in our communities since 1943.
We take a very broad approach to our work, recognizing that communities are complex and that many things are needed to make them the best they can be. That’s why every year, with our donors, we fund hundreds of innovative projects – large and small – in areas such as arts and culture, education, children and youth issues, environment, animal welfare, community health, and social development.”

Brent Hobbs (IHA) and Chris Mason (BCAS) are extremely well informed, open-minded, forward thinking people who can provide some excellent direction to changes as they are planned and implemented in out-of-hospital patient transport.

Following the BCAS/HART meeting, I met briefly with Dr. Khosla, the Chief of the Emergency Department in Nelson, to discuss the Kootenay Lake ED relationship with Kaslo. It will require some logistical planning and funding model design, but there seems to be an opportunity to support Kaslo physicians and nurses using telephone or teleconferencing methods. Also, there could be opportunities for Kaslo physicians and nurses to work part-time in the Emergency Department to see more emergency care volume. I did not get a chance to discuss this in Trail, but as that is the designated regional referral site, some regular shifts in Trail throughout the year, possibly in a double coverage role, would be ideal for Kaslo physicians to help maintain skills. They could earn income while practicing in a more acute care setting, ideally with other staff who work in Trail full-time for support.

Recommendations

12. IHA and BCAS personnel have developed an excellent collaborative relationship. Continuing to identify and address the system demands and supply challenges are key to having a seamless emergency response and transfer system. In the rural setting, it will be vital to continue paramedic staff development and sharing of ‘multi-task worker’ staff, such as the Advanced Care Attendant, in the ambulance as well as in the Health Centre. Rural centres need to explore more creative staffing models to leverage the

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7 http:vancouverfoundation.ca
skills and knowledge of the health care providers in the area. It also helps to maintain skills. IH and BCAS should continue to collaborate on the development of easy to follow emergency care protocols and algorithms for time-sensitive but uncommon health problems.

13. Follow-up on arranging HART site-based refresher training for all appropriate staff. Develop a curriculum and arrange regular sessions.

14. Explore opportunities offered by the Vancouver Foundation for paramedic development as an innovative community project.

15. Skills enhancement/maintenance - Develop a relationship with the Emergency Departments in Nelson and Trail that will enable regular shifts to be covered by nurses and physicians whose primary site is in Kaslo (or other small rural sites), ideally in a double coverage arrangement, to maintain emergency assessment and treatment knowledge and skills.

Closing Thoughts - Accountability

It is clear from visiting the IHA website, reading Charting the Course, the Strategy Map, and meeting with IHA leadership, that engaging and working with communities in the district is a priority. Most large organizations struggle with the intent to be patient-centred and community responsive while trying to manage the huge range of public expectations, Ministry programs, and the passion and politics of provincial health care delivery. There are demands on IH leadership to manage such diverse portfolios as residential care, HR, lab, DI, primary care, community hospitals, community engagement, planning, performance monitoring, patient transport, ER and other elements. All of these (and more) directly affect a small facility like Kaslo.

Hospitals in urban centres are usually managed by, and health care provided by, full-time 'specialists' in organizational management and a variety of medical, surgical, and clinical support service departments. Other than involvement on voluntary boards and fund-raising, the public in urban centres has little knowledge or involvement in the hospital. It is one of the many services provided.

However, in rural sites that have a small hospital or health centre, it is often a major employer, a stabilizing influence on local businesses, helps attract new business and people to the area, and frequently acts like a community centre in addition to providing health care. Many of the employees in such small sites multi-task and carry several different titles and roles.

On a per capita basis, it seems more likely that local people will know what is going on at the rural health centre, and people who work there, than in urban settings. That level of community engagement creates expectations of the ‘system’ (usually a health district or authority) to recognize its vital role in the area and help it set realistic goals for supporting a healthy community. That in turn leads to accountability expectations of leaders in the community as well as the overarching district.
One significant problem noted in the report above is the lack of a stable, collaborative management structure in Kaslo that involves clinical and non-clinical staff (see recommendation 4.) Also, from a Kaslo perspective, it appears that the many services that are required by and provided to the Kaslo area are managed by up to six different VPs, with district and local managers in between. I wonder if there is an opportunity to create a ‘rural bundle’ of services that is overseen by one or very few VPs, with clear explicit accountability up and down the communication chain between Kaslo (and sites like it) and IHA? Following numerous one-on-one conversations with people who attended the focus group sessions, and who were clearly engaged, two way accountability came up a lot.

Effective community engagement should be a two way street. Most rural communities have unique differences that ideally require continuous community engagement and regular local ‘face time’ to understand functional cultural differences, local priorities. There should be as much flexibility as possible to produce local solutions to local problems. People who live in rural Canada are extremely proud, hardy, opinionated, and live where they do for a reason.

16. Consider creating an explicit, simple accountability framework for managing and reporting the multiple services, roles, and expectations of the rural VCHC site and others like it.

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Although there are many people who have contributed considerable time to promoting the Health Centre and its important role in the Kaslo area, there are a few who deserve a special mention. A very large thank you to Maggie Winters, Maggie Crowe, Mary Ballon, Nicola Candy from the Kaslo region. Dr. Alan Stewart, Dr. Michael Purdon, and Karen Cairns from IHA. Linda Tarrant as meeting task-master, facilitator, and project lead.

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