EMERGENCY MEDICAL SERVICES IN NORTHERN HEALTH AUTHORITY JUNE 2024
- A Report to the Northern Health Taskforce on Emergency Department Care

Summary of David N. Ostrow's Draft Report

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The purpose of this summary report is to provide a high-level overview of the draft *Emergency Medical Services in Northern Health Authority June 2024* report written by David N. Ostrow, dated June 28, 2024.

Objective

In June 2024, Northern Health (NH) commissioned a report on Emergency Medical Services in their region. The purpose of this report was to “engage the medical staff, medical leadership and medical support staff across NH and to develop a summary report with recommendations, based upon that consultation, for the short-, medium-, and long-term priorities” of emergency medical services. The goals for these priorities are to:

1. Improve medical staff services to keep emergency rooms open.
2. Retain medical staff to work in the North.
3. Recruit new medical staff and physician extenders to the NH region.

Methods

Potential participants were identified by NH’s senior leadership team, and volunteers through discussions with NH and NH’s three regional Health Service Delivery Area Medical Advisory Committees (MACs). Participants (*n* = 28) included medical and administrative leadership from various areas of healthcare and medical staff (e.g., family and facility physicians) across the NH region.

The author of the report (David N. Ostrow) conducted one-on-one interviews with participants and the MACs via Zoom. The participants were encouraged to be candid. Themes, recommendations, and priorities were compiled from these interviews. A literature review (including online resources) was conducted to support the development of the report and assist the NH Taskforce on Emergency Department Care.

Themes

Fifteen themes were pulled from the interviews. The themes, even those identified as positive, described challenges or deficiencies needing to be addressed.

The Straw That Broke the Camel’s Back (Funding Model)

Nearly all participants indicated the current crisis began with the introduction of the Longitudinal Family Practice (LFP) model. With limited numbers of family physicians in British Columbia (BC), the LFP model drew in physicians who normally conducted comprehensive service work [e.g., Emergency Department (ED), hospitalist, and family physician–specialist work] in rural areas. Additionally, physicians in rural areas often work more than 1680 hours of care (40 hours per week

for 42 weeks per year), the full-time equivalent set forth in the LFP model, which raises compatibility issues with professional organizations requiring 24-7 care for patients and questions regarding hand-over. Further concerns with the LFP model include a change of work-life balance focus with new graduates, reduction in “rural lift” payments for working remote EDs, migration of physicians from northern communities, and lower pay for local physicians than non-local (itinerant) physicians working in EDs.

Participants agreed the LFP model is more relevant for medium to large urban settings and communities where specialist services practitioners (e.g., ED, Obstetrics and Gynaecology, Anaesthesia, etc.) are available, than for smaller, rural, or remote communities requiring continuous care.

Participants noted the importance of considering implications, consequences, and effects of funding changes on all parts of the system (e.g., small, medium, and large sites; medical staff; and patient care), and how making a positive change to one can negatively impact another.

Factors Determining Retention and Recruitment of Physicians in Rural and Remote Communities

Participants identified a variety of financial concerns: medical school debt, the relatively low rural lift payments, and inequitable itinerant physician payments (mentioned earlier).

Concerns with working conditions included a lack of nursing support, radiology technician support, and sophisticated equipment. Participants noted not all physicians were trained to use point of care ultrasound (POCUS) because not all payment models recognize being called out of hours, they are sacrificing personal and family time, and they do not want to leave their patients without care during their absence.

Challenges with personal and living conditions for those working in small, rural, or remote communities included needing to travel with additional supplies and provisions (including groceries) not readily available or accessible in remote locations and owning two residences so their spouse/family could live and work in a larger community. Cultural factors and norms also impact physicians, particularly foreign-trained physicians.

Emergency Room Status (in Canada and BC):

"… we see more and more experienced providers leaving the system from lack of remuneration, and from burnout, both from the pressures of the hours, patient complexity and the assaults to their own personal morality…"

Most participants confirmed the above statement as being relevant to physicians in British Columbia.

Unique Challenges of the EDs in Rural and Remote Settings:

"How could a physician and their family be expected to move to a remote setting when such a setting could not sustain teachers, plumbers, and other tradespeople?"
~ Participant

Unique challenges identified by participants include providing permanent staff, overcoming health impacts for patients delaying healthcare because of cultural factors and racism; travel concerns between primary and referral sites; availability issues at referral sites; increasing pressures on the acute care system; insufficient and/or unstable hospital rehabilitation, home care, mental health and substance use services for patients; and work-life balance concerns for support services (e.g., laboratory and radiology technicians).

Service Practice Supports in BC for Rural and Remote Emergency Departments:

"The Rural Coordination Centre for BC cultivates relationships, facilitates discussions, coordinates projects, and creates learning opportunities as well as advocating for rural health."

Though reported as excellent, participants noted a significant hole in this system: the lack of a "parallel system for nurses and nursing-related issues in rural and remote settings."

Team-based Care in NH:

"… what we mean by team-based care, especially where there are shortages of all categories of care providers. In this setting we mean care provided by more than one type of care provider, working to the full extent of their competencies… in various combinations that make sense for each specific site."

Participants who spoke of the above model suggested all providers within that model need to be funded under a similar model (e.g., alternative payment) to ensure balanced and equitable workload.

Caregivers' Expectations Have Changed

Research with Northern physicians illuminates interests and generational differences in physicians, highlighting things like generalists being interested in facing new challenges, accepting the need to take on specialist skills in rural areas, and a greater importance placed on work-life balance in younger generations.

Global Responses of Physicians to a Survey of Primary Caregivers and Moral Distress

> *"A similar consistent message from the interviews… indicated a profound sense of moral distress amongst caregivers due to factors that are illustrated by the wider caregiver community."*

Wider caregiver community factors highlighted in the report are from a world-wide study of clinician shortages, and include high levels of burnout and exhaustion, need for mental and health support, negative effects of delayed care, low staffing and not being able to meet patients' needs, unfilled positions, doing free work to ensure patients got care, and feelings of fragility.

Inter-personal Conflict

> *"Several [participants] identified more personal factors within the medical fraternity leading to problems in staffing. Lack of tolerance for newcomers, refusal to work with them in common settings, the feelings by some females that the professional settings were unsafe…"*

These concerns were expressed from various sites across NH. Participants also noted experiencing racist behaviour from patients.

Electronic Health Records (EMR)

MOIS, the EMR system created for NH, is in most clinics but lacks an interface engine to connect with Cerner (hospital-based system) or CMOIS (community-based system). The Telus EMR (community-based system) also does not connect with MOIS or Cerner.

Primary Care Networks (PCN) in NH

“[PCNs] provide interprofessional services which, theoretically at least, may keep patients from going to the ED. There was, however, not a lot of evidence provided to show that this is the case.”

The 11 PCNs in NH may be important in providing a platform to discuss what services are available in the PCN, where the services are located, and what the alternatives are (e.g., other communities).

Transportation

Distance and weather conditions impact both land and air travel for patients and caregivers in rural and remote regions of NH. Participants noted the desire for onsite aircraft and interprovincial transfers from EDs in the Northeast Health Service Delivery Area.

Medical Education

NH struggles to recruit and retain medical students and Practice Ready Associate (PRA) Program candidates, particularly in small, rural, and remote communities. Participants suggested the University of BC needs to do more to help encourage students to train in the North. With the allure of resources in larger communities (e.g., day care, rental space, recreational facilities, spousal job opportunities, etc.), participants recommended promoting the ability to acquire extra skills, training, and certifications (e.g., POCUS) when working in smaller communities.

Medical Staff Human Resource Plan

The NH Medical Staff Human Resource plan for 2022-2027 anticipates needing more physicians, but participants stated it does not account for a growing workload in the future. Participants noted a retiring senior physician may need to be replaced by two or three more junior physicians because of the shift towards prioritizing work-life balance. In addition, many communities may need to band together to provide needed services for their community (“community of communities”) or adjusting their primary care model of care to one that is less physician centric.

Leadership Programs

“Leadership payments are very low in BC health authorities, which leads physicians to invariably consider them add-on to their clinical roles.”

NH has access to leadership coaching funding; however, it was not clear if the participants were aware of this. Participants said the uptake of sponsored leadership events is low due to their clinical workload.

Recommendations and Setting Priorities

Table 1 summarizes the eight recommendations established by the interviews with the participants and provides a guide for prioritizing the work moving forward.

Table 1.

Summary of the Recommendations and Priorities Outlined in the Emergency Medical Services in Northern Health Authority June 2024 Report.

Recommendations	Priority Status
1) Recalibration of the remuneration system for family medicine including rural settings and ED coverage in the North.	**Short Term** (High Priority)
a) It's important to be cognizant of the effects of change on care in small and medium sized settings where resources are limited, and rewarding, not penalizing, practitioners' flexibility. b) Tie payments to ED work needed by a whole community, its complexity, and remoteness in a transparent formula. c) Increase the "rural and remote advantage" baseline to funding to encourage local physicians to take on ED activities in their community. d) Ensure local physicians are paid the same to work in the ED as itinerant physicians, using an alternative funding model. e) Change itinerant physicians' contracts to automatically include transferring to the nearest open ED to cover increased workload when a community's ED is put on diversion. f) Change contracts in rural community ED physicians to promote continuity of care (e.g., include care for patients they admit). g) NH to take the lead on a pool of potential floating (itinerant) ED physicians. h) Consider paying local physicians for on call ED services via the Medical On-Call Availability Program (MOCAP). i) NH should have flexibility to negotiate variations to provincial contracts in unique cases (e.g., border communities where a significant proportion of patients come from outside the province). j) NH needs to have representatives at the table alongside the Doctors of BC to help HEABC understand the unique needs of the North.	

2) **Rethinking Physician Human Resources.**	
a) Review the current definitions of full-time physicians (1680 hours) and its human resource implications (e.g., how many physicians BC will need in the future, particularly if physicians' hours are limited).	**Medium Term**

3) **Rethinking the Emergency Room care teams in rural and remote BC.**	
a) Ensure all care team members are working to their level of competence and skill in the ED. b) Train care team professions together to encourage trust in competence and reduce inter-professional conflicts. c) Look at where care teams can solve staffing shortages and how those teams can be rolled out. d) Pay care team professions using a similar model (for physicians, a model alternate to fee-for-service). e) Train, accredit, and add Physician Assistants to the ED care team — working under the supervisions of a physician or nurse practitioner (ED-trained). f) Advocate for provincial investment into an ED skill training program (solo and care team) for nurse practitioners. g) In the ED, review renumeration of payment models for NP and Physicians to reduce chances of inequitable undertaking of complex versus "easy " patients	**Medium Term**

4) **Rethinking the concept of "communities of communities" for continuous care in the North.**	
a) Consider a model where each community might have equal daytime services by a primary care practitioner(s), but ED coverage in one community only where resources are concentrated. b) Due to unbalanced local services, the model requires discussions lead by NH to obtain buy-in from Indigenous partners, industry, and community leaders. c) Using Valemount and McBride as examples, work with communities and their care professionals to craft models to address their unique needs.	**Medium Term**

5) **Prioritizing patient flow and post-acute care settings.**	
a) Ensure NH is using the most up-to-date patient flow techniques and tools. b) Consider congregating ALC patients into single sites and creating alternative care sites (e.g., repurposed units near the acute care setting; "Skilled Nursing Facilities" in the United States). c) Advocate for the addition of long-term psychiatric facilities (for complex and/or difficult to treat cases).	**Short Term**

6) **Boosting the support systems.**	**Long Term**

a) Consider a remote support system for all care givers working in the ED (e.g., nurses and paramedical professionals), similar to what's available for physicians. b) Consider programs or specialist counselling services for moral distress of ED professionals (e.g., for PTSD and work-related traumas). c) Establish an inter-provincial agreement or on-site aircraft for unique transfer issues specific to the Northeast and Northwest. d) Work with other health authorities to improve data transfer between EMR systems.	(awaits full implementation of new model of care)

7) **Developing alliances to improve community support.**	**Long Term** (requires cultivation of communities, their members, and leadership)
a) Work with communities to bolster attractiveness of working in the North to PRA Program candidates and medical students by building community support and exploring tangible benefits (e.g., housing, resources, recreation, etc.).	

8) **Using leadership programs to reduce inter-personal conflicts and moral distress.**	**Short Term**
a) Focus leadership programs on dealing with colleagues, care teams, and communities under the current stressors.	