Resident Doctors of BC
Response to the Ministry of Health Policy Papers

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With thanks to the Resident Doctors who answered our survey and attended our focus groups
Resident Doctors of BC Response to the Ministry of Health Policy Papers

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Executive Summary

In 2015, the British Columbia Ministry of Health (hereafter, ‘the Ministry’) released a series of policy papers committing to addressing complex issues in the health care system through a collaborative process. Resident Doctors of BC appreciates the opportunity to participate in discussions and to help shape the future of the health care system in which our members intend to practice. Resident Doctors of BC agrees with comments made by Doctors of BC that lasting system-level change must be undertaken collaboratively and incrementally, through the thoughtful application of a continuous quality improvement approach and the support of appropriate incentives.

While budgetary constraints and sustainability are always key concerns, the patient and provider experience must not be eroded by allowing health care initiatives to be driven by the goal of reducing costs to the system. Failing to fund the proposed initiatives, particularly in the early transitional stages, could result in unintended consequences with respect to quality of care. Careful implementation focused on patient and provider health will allow for a graduated transformation of our system that will benefit patients and providers along with the bottom line.

In this paper, Resident Doctors of BC provides an overview of our response, which reflects our members’ input on the policy papers. The response focuses on areas most relevant to resident physician practice, training, and advocacy priorities: namely, proposed changes that address primary and community care, health human resource planning, rural health care, and information management and technology. Given the focus of the policy papers on changes to primary care, our discussion was focused on primary care reforms, despite a large proportion of members who were consulted coming from specialist training backgrounds.
Generally, resident doctors (or ‘residents’) agreed with the overarching goals laid out in the policy papers. Improvements in integration of primary and community care, communication among health care providers, supports for target populations, access to specialized services, and supports for physicians and allied health professionals in rural areas are all objectives that received broad support, though questions were raised about the lack of clarity regarding how the proposals would move forward. We look forward to working with the Ministry on the implementation of initiatives and determining the best way to improve the health care system in BC.

Specifically, residents support further investment in non-acute community beds to reduce demands on hospitals, as well as patient education to the same effect. This investment and increase in residential services must be funded separately from acute care and occur prior to changes to acute care to protect patients from service gaps. A clear distinction should be made between the services provided by after-hours non-acute care and those provided by the walk-in clinic model in order to effectively support a shift from the current walk-in model to an after-hours one. Physicians should be further supported in the implementation of innovative patient scheduling to reduce patient wait times and improve access to care.

Residents expressed a clear preference for practice models that are dynamic and responsive to the needs of individual communities. We encourage the Ministry to explore mobile multi-disciplinary teams using technology in addition to stand-alone team-based clinics, though solo places should remain an option in areas where this best serves population need and practitioner preference. Family practice residents are keen to combine outpatient practice with in-patient care, but require supports to help balance their responsibilities in both areas, as well as support for ongoing training in hospital-based medicine.
Residents clearly support rural health services and place a high value on rural rotations during their training. We encourage mandatory rural rotations as part of residency training, with consideration for residents with extenuating circumstances, and increased financial support for residents interested in doing elective rotations in rural settings. We further advocate support for rural medicine through telehealth and visiting specialists.

We found the discussions in the Health Human Resources paper to be greatly encouraging. Resident Doctors of BC advocates for the creation of a coherent provincial framework, forecast, and deployment methodology, which would be available to residents, medical students and the general public, and updated on a regular basis. We support initiatives to create healthy work environments and to accommodate effective disability and wellness protection. We encourage interdisciplinary training to occur early in residency and continue throughout practice to support effective staff and skill mix.

Finally, residents strongly support the creation of a provincial centralized electronic medical record. We believe that the standard of care for every patient should be that their health care provider has rapid 24/7 access to their complete medical record. We encourage the development and maintenance of a province-wide centralized electronic medical record that can be accessed by care providers working in both hospitals and community clinics across the province. Any such system should be developed with input from physicians at all stages of practice, and resident doctors are keen to contribute to the development of, and continual improvements to, such a system.

It is clear from our consultation with BC’s resident doctors that they are interested in participating in and contributing to effective and lasting change around these issues. Residents are committed to providing the
best patient care possible and advocating on behalf of their patients. Resident Doctors of BC looks forward to continuing to engage in discussions around specific actions and initiatives as they are developed further in the coming months and years.
Introduction

In 2014, the British Columbia Ministry of Health (Ministry) released Setting Priorities for the BC Health System, which outlines the strategic and operational priorities for the delivery of health services across the province. In 2015, the Ministry released a series of cross-sector policy discussion papers (hereafter, ‘the policy papers’) that build on this earlier strategic document. The papers are as follows:

- Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources
- Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Information Management and Technology
- Future Directions for Surgical Services in British Columbia
- Primary and Community Care in BC: A Strategic Policy Framework
- Rural Health Services in BC: A Policy Framework to Provide a System of Quality Care

In this paper, Resident Doctors of BC provides feedback on the proposals outlined in the policy papers, specifically commenting on areas most relevant to resident physician practice, training, and advocacy priorities. The response focuses on the proposed changes that address primary and community care, health human resource planning, rural health care, and information management and technology (IMIT).

The first section describes the member consultation process that Resident Doctors of BC undertook in relation to the policy papers. Section two provides an overview of key issues raised by our members in relation to the policy papers. Sections three through five provide more detailed feedback pertaining to the Primary and Community Care, Rural Health Services, Health Human Resources, and IMIT policy papers respectively.
1. Consultation Process

Following the Ministry’s release of the policy papers, Resident Doctors of BC undertook a thorough review of the papers with the objective of seeking input from our members. To facilitate feedback, enable meaningful engagement, and invite input on the proposals, focus groups were held in Prince George and Vancouver. To solicit a broader range of opinions, an online survey was also developed. The survey was sent electronically to all members on December 18, 2015, and a reminder was sent to all who had not participated by January 4, 2016. The survey was closed on January 11, 2016. Quantitative and qualitative analyses of the data were performed by NRG Research Group.

Resident Doctors of BC received considerable input from its members during the consultation period. This indicates a strong resident interest in contributing to the conversation on the future of health care in BC through the identification of innovative solutions to address gaps and inefficiencies in patient care.

2. Response Overview

Resident Doctors of BC appreciates the opportunity to provide feedback around proposed health care system changes, as well as the Ministry’s collaborative approach in sharing the documents for comment. Our organization is optimistic that the policy papers reflect proposed actions and that further discussion of the proposals will allow meaningful input on what the specific actions will be.

The Ministry identified a number of goals, including improved integration of primary and community care, improved communication among health care providers, increased supports for target populations, improved access to specialized services, and strengthening of supports for physicians and allied health professionals in rural areas. Resident
Doctors of BC supports these goals in principle and acknowledges the Ministry for its work in identifying and prioritizing these issues.

However, there remain some significant concerns and questions. During the consultation process, residents noted that the policy papers do not outline how implementation of the proposals will occur, and what supportive structures will be put in place to ensure their success. The papers also did not indicate the extent to which residents will be allowed to participate in the design and implementation of these initiatives.

The details of what the Ministry hopes to achieve and how the proposals will move forward raised questions. For example, issues related to proposal funding, structural support, and —where applicable— compensation mechanisms will require further consideration and development.

There were some general concerns about loss of physician autonomy in the course of implementation of certain initiatives. For example, the potential erosion of the leadership role that physicians play in team-based care environments could have significant ramifications for patient care. Given physician liability for patient outcomes, these aspects of the proposals raised significant concern. It should be added that physician objection to these aspects of the proposals was reasonably balanced with recognition that the physician leadership role must also include responsibility to facilitate the effectiveness of health care teams.

In the sections that follow, input is provided on each of the Primary and Community Care, Health Human Resources, Rural Health Services and IMIT papers in turn. Where there are areas of overlap between the policy papers, input is generally provided once, in connection with the proposals most relevant to residents.
3. Primary and Community Care

The Primary and Community Care Policy Paper is premised on the Ministry’s view that, over the coming two years, the health sector needs to make substantive and measurable progress to significantly reduce demand on emergency departments, medical in-patient bed utilization, and residential care. The Ministry’s extensive research and consultation suggests that improving the effectiveness of primary and community care is key to achieving this goal.

Resident Doctors of BC generally agrees with the objective of improving primary and community-based health care services, including health promotion and disease prevention. However, it was felt that considerable additional investment in non-acute beds in the community would be required before reductions on hospital in-patient bed demand would be realized. Residents felt strongly that investment in community services and non-acute beds should occur before any reduction in the availability of already strained hospital-based services.

Residents also suggested that hospital capacity could be improved by increased home visits, more investment in advanced care planning and palliative care, and improved patient education around appropriate use of health system resources. Enhancements to the level of care provided in residential care and assisted living facilities may also help reduce transfers to acute settings.
Recommendations

1. Invest in non-acute community beds to reduce demand on hospital in-patient beds, and make these investments before changing availability of hospital-based services.
2. Increase home visits and invest in advanced care planning and palliative care. Increase services and level of care provided in residential care/assisted living facilities to reduce transfers to acute settings.
3. Increase patient education around appropriate use of health system resources to reduce hospital utilization.

Team-based Family Practices

The Ministry proposes working with the General Practice Services Committee (GPSC) to develop a plan to support the establishment of multi-disciplinary team-based family practices as full-service solo practitioners retire. The intention is to develop family practices based on population and patient needs, rather than “relying on individuals or groups of physicians randomly establishing practices.” The Ministry notes that the objective will be to incrementally attach individuals and families to a team practice rather than an individual practitioner, while supporting the practice of a most responsible family physician. The objective is to increase patient attachment and provide opportunities for innovative care. Consideration could be given to compensation models that include salaried, contractual, and population needs-based approaches.

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The majority of residents surveyed intend to eventually practice in a multi-disciplinary team-based model. They predicted that in order to feasibly practice in this type of model they would require resources in the form of administrative and support staff, allied health services, nursing support, compensation for meetings and collaborative projects, and clinic overhead incentives. Many of these supports are already provided for specialty physicians who work in team-based settings, but not yet provided for family physicians. It was also stressed that physician autonomy would be important, with the physicians as leads on the clinical team and actively involved in administrative decisions. Resident doctors strongly support the notion of the family physician as the ‘Most Responsible Physician’ leading the clinical team.

The Bridge Community Health Clinic in Vancouver was noted as a successful example of team-based care provision for a population with specialized needs. It is a primary care clinic for refugee claimants, offering the full scope of family practice services. The staff includes a cohesive, well-managed team of physicians, nurses, nurse practitioners, interpreters, settlement workers, a nutritionist, and a psychiatrist. Residents cited this as a successful model that they would consider working in once in practice.
Resident Doctors of BC is in agreement with Doctors of BC that in addition to taking on the role of Most Responsible Physician, family physicians should have the opportunity to be involved in the recruitment of allied health practitioners to these practices. We are further in agreement with Doctors of BC that the practice model itself does not determine quality or patient-centredness of care and, in many cases, supported solo-practices may be the better alternative.

If this proposal is implemented, it is imperative that the shift toward team-based practice be undertaken collaboratively with physicians, in an incremental and measured manner, and supported by incentivized, rather than prescriptive, approaches. It is important that, as we move forward, we incorporate the lessons learned from similar clinics that have not been as successful as the Bridge Clinic. For example, the Primary Care Clinic at the Jim Pattison Outpatient Care and Surgery Centre in Surrey has struggled with physician retention, patient flow management, and effective scheduling, and other clinics in the Centre have had problems with management and effective staffing.

Resident Doctors of BC is in agreement with Doctors of BC’s concerns about the Ministry’s proposed model for multi-disciplinary care. Most worrisome was the suggestion that patients may be transferred from the care of their current physician to the care of a specialized multi-disciplinary care clinic. There is concern that, other than in cases where a patient’s current physician cannot accommodate complex care needs, this proposal would undermine existing longitudinal relationships. Additionally, if the intention is to build new standalone clinics, the significant costs will need to be justified.

In some cases it may be more effective to develop mobile ‘wrap around’ multi-disciplinary care teams with expertise in chronic conditions and/or mental health and substance use issues. These mobile teams could have a footprint in, and provide support to, a number of existing
physician practices. Our residents cited a successful example of this model: in Fraser Health, they described a ‘virtual multi-disciplinary team’ where a nurse works with 20 different physicians to provide outreach and home visits to frail seniors in the community. It may be fruitful to explore these models given that they appear to be cost-effective and well-received by both physicians and patients.

**Recommendations**

1. To support the creation of multi-disciplinary team-based care practices, family physicians should be the Most Responsible Physician, and have the opportunity to be involved with the recruitment and management of allied health practitioners and staff.
2. Provide the option of solo-practices in locations where this best serves physician and population needs.
3. Incentivize the transition to team-based practices, using an incremental and measured approach.
4. Consider using mobile multi-disciplinary teams and technology to support longitudinal practices, rather than creating new stand-alone clinics.

**Walk-in Clinics**

The Ministry of Health intends to look at policy and regulatory options for framing the role of walk-in clinics, and plans to ask the Medical Services Commission to complete a review of compensation levels and fee-for-service requirements for this health service.

Residents felt that clear regulatory distinctions need to be made between care typically provided at walk-in clinics and care provided by after-hours non-acute care for problems requiring same-day attention.
While there is certainly a need for timely, after-hours care to deal with non-acute problems that might otherwise fall onto an emergency department, walk-in clinics that operate during office hours and provide high-volume low-complexity care or chronic disease management should be discouraged, as they do not promote patient attachment and continuity of care. A majority (56%) of current family medicine residents do not intend to practice medicine using the walk-in clinic model. Rural residents were especially supportive of a review of walk-in clinics, given that in smaller communities general practitioners often provide the full scope of around-the-clock in-patient and outpatient longitudinal care with little reliance on the walk-in model.

Rural residents suggested that a successful after-hours care model that still focuses on attachment might help reduce the need for walk-in clinics in our current system. Such a model has been employed in rural communities in BC, such as Haida Gwaii and Bella Coola, where all patients are attached to a primary care clinic with multiple physicians; the doctor on call for the emergency department also does walk-in appointments in the clinic during the day. If the matter is non-urgent, patients may book an appointment for a later date. While practically speaking not all rural practices can be easily extrapolated to urban environments, some of these mechanisms may be more broadly applicable.

In addition, residents also suggested that it might be fruitful to work with family physicians (through the Divisions of Family Practice) to develop innovative approaches to appointment scheduling to ensure that patients are able to book same-day or same-week appointments with their family physicians. These types of scheduling practices will discourage the use of walk-in clinics for sub-acute problems and issues requiring timely follow-up.
In-Patient Care

The Ministry of Health intends to review the practicality of physicians working in hospitals under the individual practice model. For urban areas they are looking at integrated clinics providing care into hospitals versus the current hospitalist model.

Our survey suggested that 62% of all residents would like to integrate community and hospital-based care. In our urban focus group, residents declared an interest in working in hospitals and felt it was an opportunity for greater breadth in their scope of practice and longitudinal care for their patients. However, most residents noted that, in current models, providing this type of care was unattractive. Residents feel that balancing in-patient and outpatient needs poses a significant challenge: currently it is quite difficult to provide good quality in-patient care while structuring it in a way that ensures outpatient clinic responsibilities are also met. As a result, they noted most family physicians in current urban practice models don’t have hospital privileges.

Recommendations
1. Develop clear distinctions between after-hours non-acute care and walk-in clinics, and provide patient education on determining when urgent care is needed. Walk-in clinics operating during office hours that provide high-volume low-complexity care or chronic disease management should be disincentivized.
2. Support family physicians in developing innovative approaches to appointment scheduling to reduce patient wait time to access care.
Among participants from our rural focus group there was consensus that if family doctors are to care for their patients while in the hospital, then all family doctors in a community must participate to prevent the burden from falling on just a few physicians.

Residents agreed that in order to improve continuity of care, it is desirable to have a physician who has previously treated a patient provide care for that patient in hospital, if the admitting problem is within their scope of practice. However, residents felt that there are currently insufficient incentives for family physicians working in outpatient practice to care for their own patients in hospital. They cited examples in some health authorities of hospitalist “doctor of the day” physicians who admit and care for patients unattached to a family physician: these individuals earn substantially more than family physicians who admit their own patients to the same hospital, and this serves as a disincentive to practicing in-patient care.

It was recognized that family physicians providing in-patient care require support in the form of training and continuing medical education, given the complexity and constant advances in the area of in-patient medicine. Based on their experiences, residents felt that the in-patient clinical skills of admitting physicians were related to patient outcomes and the length of stay, and cited this as an important reason to ensure ongoing training for any physicians providing hospital-based care.
Residential Care

To support and better meet the needs of older adults with moderate to complex chronic conditions, and those with moderate to severe mental illness and/or substance use issues, the Ministry of Health is looking to develop specialized community practices that are linked to higher levels of care, including residential care services.

Residents strongly recognize the need for increased residential care capacity. At our rural focus group, an attendee noted that recently the wait in her community for a long-term care bed was 200 days: in order to care for patients in the interim, community respite beds were used. Residents felt that increasing residential care capacity would decrease the demand on hospitals, but cautioned that to ensure there are no gaps in care delivery residential care beds should be established before funding is shifted away from hospitals.

Recommendations

1. Develop attractive practice models and adequate incentives for family physicians to provide in-patient care.
2. Standardize the incentives for hospital admissions by family physicians to reduce the disparity in earnings between the “doctor of the day” and physicians who admit their own patients.
3. Provide ongoing training, beginning in residency, for hospital-based primary care physicians to ensure clinical skills are current to the evolving practice.
Recommendations

1. Develop increased residential care capacity with funding separate from acute care, and then incrementally shift funding away from hospitals after the demand on hospitals decreases.

4. Rural Health

As resident doctors often practice in rural communities for several months over the course of their training, our members have insight into some of the barriers and challenges faced in rural practice. We feel that the experiences and insights of our members will provide a clearer picture of the ways our Province can better address rural care in the future.

Resident Engagement in Rural Practice

Residents are keenly interested in rural health, with many citing an interest in practicing rurally in the future. Most residents also find clinical placements in an underserved area to be an important part of their training, and there is general support for having mandatory rural rotations in residency, provided there are

![Likelihood of Practicing in a Rural Setting](image-url)
considerations for residents with extenuating circumstances that would make such placements a hardship.

Residents identified three main barriers to the pursuit of training opportunities in underserved areas: housing, funding, and elective availability. Rural training opportunities are often for an extended period of time, and obtaining housing can prove a significant barrier; housing is not always provided by health authorities, and the housing they do provide can be limited in amenities or are not family-friendly. Arrangement of and paying for alternative housing options often falls onto residents. By assisting residents with improved housing support, and by maintaining an awareness of quality of life when arranging housing, rural rotations may become a more attractive option.

Rural placements often result in additional costs to residents, and current funding models do not offset these costs. Food costs increase in rural communities, and extended placements in rural communities provide additional costs for residents, many of whom are still paying monthly bills in their home community while practicing rurally. In addition, current resident travel allowances have funding caps that do not reflect the cost of travel to various communities: residents required to travel by car to communities served by the northern routes of BC Ferries may exceed the travel allowance provided. By making additional rural stipends and funding opportunities available, the province could offset additional costs to residents, making rural training programs more attractive.

By removing financial and logistical barriers, we may see the 44% of residents who indicated lukewarm interest in practicing in rural communities become more invested in rural practice. As residents who train in rural communities are more likely to settle in rural communities
during practice, these incentives will benefit rural communities as a whole.

**Recommendations**

1. Continue mandatory rural rotations as part of residency training with considerations for residents with extenuating circumstances.
2. Support training in underserviced areas by creating additional rotations with support for housing.
3. Advertise rural and remote training opportunities to residents, and provide support in accessing and coordinating such rotations.

**Health Promotion and Disease Prevention**

The Ministry of Health proposes that regional health authorities develop three-year local community plans on health promotion and disease prevention for all rural and remote communities. The stated purpose is to create environments that foster healthy behaviours and programming that improves population health.

Resident doctors support the development of such community plans, although several concerns were identified. Such plans will need to be developed with substantial community input (rather than solely or primarily from the health authority level) in order to have community buy-in. Resident doctors training in rural and remote communities have unique perspectives and insight into community health needs, and their views should be incorporated into community plans whenever possible.

Resident doctors are hopeful that community health plans will directly address the social determinants of health. They acknowledge that in
addressing social determinants of health, opportunities to shift resources from acute care to primary care and prevention may be identified. Such changes, over the long term, would certainly be beneficial to community health. Residents are mindful, however, that any abrupt shifts of funding could have detrimental effects on access to acute care in the short term. As such, increased funding for preventative care must not occur at the cost of abrupt cuts to acute care funding.

Residents also suggested that community plans should specifically address the issue of prolonged acute care stays due to social determinants of health or other issues linked to stability and access to health care.

**Recommendations**

1. Rural and remote community health plans should be developed with community input and, whenever possible, with input from resident doctors training in that community.
2. Community plans that identify opportunities to shift focus and funding from acute care to primary and preventative care should be implemented in a graduated fashion such that access to acute care is not compromised in the short term.
3. Community plans should specifically address the issue of prolonged acute care stays due to social determinants of health or other issues linked to stability and access to health care.

**Primary and Community Care in Rural Communities**

The Ministry of Health proposes that primary and community care in rural areas be provided through new integrated multi-disciplinary primary and community care practices. The Ministry’s preference is that
these teams would be co-located with physicians fully incorporated into the teams.

There are many possible benefits of co-location, including decreased travel time for patients and easier collaboration between practitioners. However, mandatory co-location is a significant concern for resident doctors. First, there are many communities in which an existing practise model is working well. For example, residents cited a community in Alberta where family practitioners worked out of an in-hospital clinic with access to physiotherapy and occupational therapy in the same building. The local health authority was adamant that the family physicians move to an out-of-hospital, co-located clinic, but the physicians rightly felt that the existing model served their patients’ needs. In such a situation, forced co-location would be counterproductive to its aims.

Second, the forced co-location of multiple practitioners could in some circumstances lead to the loss of a practitioner in a neighbouring community, resulting in decreased access to care. As a cautionary example, residents described a community in northern Alberta in which a nurse practitioner was the only primary care provider. When a co-located practice was created in a neighbouring community, the nurse practitioner was pressured into moving to join the co-located practice, and the first community was left without a primary care provider.

Both of these examples illustrate the fact that co-location can, in some circumstances, negatively impact patient care. Resident Doctors of BC would highlight the need for flexibility on a community-by-community basis, rather than top-down mandates from health authorities that may overlook circumstances where communities would be detrimentally impacted by co-location.

As suggested by the policy paper, improved IMIT will allow those physicians who are not physically co-located to be virtually linked with
other members of the interdisciplinary team. If improvements in scheduling and record keeping were implemented (such as integrated referral and scheduling for multiple types of practitioners and a centralized patient medical record), the proposed ‘phasing out’ of the solo practitioner model by retirement or recruitment of new physicians need not occur.

**Recommendations**

1. A shift to co-located practices should be implemented in concert with a province-wide strategy to improve IMIT, to allow virtual linkage of health care practitioners.
2. Efforts to co-locate should be individualized to each community and its established practitioners, with the understanding that co-location may not be ideal for every community.
3. In communities where co-location is not implemented, a similar level of resource support should be provided to enable virtual linkage of practitioners.

**Specialist Consultation and Support**

The Ministry also intends to augment integrated multi-disciplinary primary and community care practices with visiting specialist support and telehealth consultation. When asked which of these should be given priority in order to improve access to specialist care, 54% of residents felt they were both of equal importance. Lack of access to colleagues and
specialists was also commonly noted as a barrier to rural practice.

**Recommendations**

1. Support rural practice through increased access to specialist care through both telehealth and visiting specialists.

**Emergency Health Services and Emergency Patient Transfers**

The Ministry has proposed that BC Emergency Health Services (BCEHS) 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.

In principle, resident doctors strongly support such a review. Importantly, our members have noted that a significant barrier to practising in rural communities is a lack of consistent systems and logistics for transferring patients to higher levels of care, which cause delays and impact the ability to provide the best possible patient care.

A review of such a complex system, in order to be most objective, should likely not be undertaken internally by BCEHS.

**Recommendations**

1. A third party, informed by BCEHS, should undertake the proposed comprehensive strategic and operational review of inter-facility patient transfers.
5. Health Human Resources

Health Resident Doctors of BC recognizes the complexity of health human resource planning, particularly given a changing population and evolving service needs. Resident Doctors of BC supports increased planning and a realignment of training priorities in BC to ensure there is a smooth transition from training to practice, and sufficient available physicians to meet population need. We look forward to working with stakeholders and the government in the creation of a coherent framework, forecast, and deployment methodology, as well as providing the physician trainee perspective in health human resource discussions.

As practicing physicians begin to transition into retirement, Resident Doctors of BC also notes that there is a need for structures to be in place to facilitate handover to physicians starting independent practice. There is also a need to address the mechanisms by which new physicians take over practices, and to ensure that access to resources is equitable throughout this transition.

The Human Health Resources (HHR) policy paper discusses how any health service delivery team must have five core characteristics in order to provide quality patient care. We commend the Ministry's critical evaluation of our current system and the revisiting of the conceptual framework of HHR. Two key ‘core characteristics’ from the conceptual framework are of striking importance for medical residents. Firstly, the skills and competencies required to deliver patient-centered health services need to be assessed through the lens of social accountability. Secondly, organizational support and leadership needed to deliver service effectively is a critical building block where physicians in training should be involved in the decision-making process.

Resident Doctors of BC supports members’ education and encourages the development of skills and competencies to deliver patient-centred
health care. We also support safe and healthy workplaces that protect not only the physicians and allied health, but also patients and their families. We encourage efforts to improve leadership and support for physicians to ensure they are able to provide the best care possible for British Columbians.

**Recommendations**

1. Engage resident doctors in HHR planning discussions to inform the creation of a coherent framework, forecast, and deployment methodology.

**Recruitment and Retention**

The Health Human Resources paper highlights the need to support ill and injured health care providers. A safe and healthy workplace is a vital requirement for a healthy, engaged, and productive health care workforce. Health care workers are one-and-a-half times more likely than the average Canadian to be off work due to illness or disability.\(^2\) Supporting ill and injured providers through effective disability management contributes to the retention of employees with valuable skills. Health service providers invest a significant amount of time, effort, and money in their chosen occupation. When disability removes a health service provider from the workplace, it has negative impact on both the provider and the patient.

Resident Doctors of BC supports safe and healthy work environments, as well as optimizing the work environment for individuals with illnesses or injuries. Our members indicated that one barrier to rural practice is

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the difficulty of taking leave and finding locum coverage for both medically necessary and personal time away from work.

Psychological workplace health is also a focus at the national level. Resident Doctors of BC supports efforts to improve the mental health and wellbeing of all health care workers, and supports the adoption of policies that promote a psychologically healthy workplace, such as WorkSafe BC’s policy on Workplace Bullying and Harassment.

**Recommendations**
1. Increase support for ill and injured physicians and protect their wellbeing through effective disability management systems and healthy workplace policies.

**Transition to Practice**

The policy paper notes that professional education programs prepare students with the clinical skills required to treat patients, but that the academic medicine setting is often different from the workplace. Transition to practice is a key concern for residents, both in terms of job availability and preparedness.

The majority of the respondents (68%) noted that assistance with a smooth transition to independent practice was not a feature of many
available job opportunities. This is a key issue for our membership as 91% noted that assistance with a smooth transition to independent practice is a significant driver in their decision-making when assessing practice opportunities. Residents are keen to embrace support and mentoring around transition into practice (office management, for example) but in many cases it is not available or accessible. Resident Doctors of BC would be willing to collaborate with the Ministry and stakeholders to identify, develop and make available such supports to residents.

One suggestion from our urban focus group was to develop a program that allows for physicians who plan to retire within five years to connect with early career physicians who would over time transition into the role of practice leader. It would be important to ensure that this relationship be a mentorship and learning opportunity, with mutual benefit to both mentor and mentee.

**Recommendations**

1. Create and promote innovative supports for residents transitioning to practice.

**Integrated Health Human Resource Planning and Training Inventory**

Resident Doctors of BC supports the creation of the Integrated Health Human Resources Planning (IHHRP) model and looks forward to having this information available to our members to assist them in career planning. We also support this information being made available to the general public so they may access accurate information about the number of available positions compared to population need.
Access to this information as early as possible was encouraged by our membership, and many respondents wanted more information on prospects, employability, and expected demand in urban versus rural settings. While 32% of those surveyed received some information about job availability in early medical school, most did not encounter this information until early in residency. A remarkable number (23%) reported never learning about HHR information pertaining to their specialty. It was further reported that the information was often provided anecdotally, rather than through formal delivery mechanisms. The majority of respondents felt information on Health Human Resources would be most helpful if provided early in medical school, but supported receiving information continuously throughout training. 44% of residents said that having access to accurate HHR projections around job prospects in their specialty would have changed their current career trajectory. This suggests that that providing timely and accurate information may ameliorate issues of physician shortage (and surplus) in various specialties.

National access to this information would also be beneficial, as residency training is nationally coordinated through the Canadian Residency Matching Service, and many trainees apply from outside of BC. These trainees often do not have formal or informal opportunities to access information about BC’s anticipated physician needs. Information
on the population needs and career prospects will assist them in selecting a training location, and—if positions are available—may encourage physicians to remain in BC upon completion of training.

The Ministry also intends to inventory and assess current education and training programs, and use the inventory with planning models to realign these programs to meet population health needs. Residents recognize the importance of physician human resource planning to meet population needs: not only does this allow them to engage in long-term career planning, but also ensures timely access for their patients to primary and specialty care.

Furthermore, planning models should be frequently updated. The process from medical school matriculation through to practice can last up to eleven years, and planning models of five to ten years may not be long enough to provide adequate information during important decision phases. Most residents noted that they would like this planning information to be accessible publically on a website so that it is readily available for career decision-making.

Residents felt that HHR planning should also focus on ensuring access to continuing professional development (CPD). Access to CPD begins in residency, and continues throughout practice, but is inequitably distributed and difficult to access for some rural physicians. 43% of residents stated that access to professional development was a deterrent to practicing in a rural setting. To mitigate the issue, residents suggested supports to attend conferences and course updates (including course subsidies), protected time, and travel support. Residents also cited a need for rural continuing medical education conferences and rounds, as well as videoconferencing capability for events occurring outside of rural locations.
Rural Health Human Resources Planning and Management

In the Rural Policy Paper, the Ministry states that the need for generalist practice in rural and remote communities is a practical reality and that this must be balanced against the need for quality and safety of those services. This is supported by the sentiments expressed in the rural focus group.

Strengthening generalist training in residency education is a longitudinal approach that will not only serve the doctors that are being trained, but also the communities they will likely serve in. As it stands currently, residency training continues to sub-specialize and remain based in tertiary care sites. To alter this trajectory, a collaborative approach is required such that resident doctors must have the opportunities to train in locations with generalist practices, regardless of the specialty they are in. As noted by the Doctors of BC paper, “practitioners such as

Recommendations

1. Implement a strategy for health human resources that is tailored to the specific needs of urban and rural settings.
2. Create a nationally coordinated longitudinal HHR plan and a regularly updated forecast available for medical students and residents to help guide their career choices.
3. Support and incentivize accessibility to CPD to increase retention of medical professional in rural and underserved areas.
general surgeons, general internists, and general pediatricians are an asset to rural medicine and should be actively supported.”

Additional exposure during residency in underserviced areas was widely supported by our membership, with 61% of survey respondents noting it is an important feature of their training, and 78% favouring making these rotations mandatory. The urban focus group noted that even if direct exposure did not result in the resident choosing to practice in an underserviced community, it would create an understanding of the unique needs of those communities and foster collegiality with those who practice rural medicine through understanding and experience.

Residents felt that further support for exposure to rural training opportunities would potentially translate into heightened interest in working in rural BC after graduation. Such support could include increased funding for rural elective placements, housing supports for residents completing rural rotations, the creation of an easily accessible database of rural preceptors, and ongoing teaching training for those preceptors.

**Recommendations**

1. Obtain agreement on the definition of generalist practice.
2. Establish and promote a network of rural specialists with general practices for resident doctors to contact for elective and selective training opportunities.
3. Encourage exposure to rural training through increased support for residents to complete rural medical electives.

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Rural Incentive Programs

The Ministry recognizes the challenges of attracting and retaining physicians, nurses, and other health care workers in rural and remote communities, and therefore proposes to review and make recommendations for improvements and additions to incentive and support programs for health human resources. These include introducing more flexibility into existing physician incentive programs to better respond to community service needs, as well as developing incentive programs and supports for nurses and allied health professionals.

In considering issues related to health human resources, the Ministry may wish to widen its scope and look at ways to encourage and support individuals already living in rural areas to pursue a career in health care. Given the evidence that medical students from rural areas are more likely to return to these areas to practice, it is important to reach potential students as early as possible.

Recommendations

1. Support individuals who live in rural areas to pursue careers in health care.
2. Introduce flexible incentive programs for physicians and create additional incentives for allied health professionals.

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6. Information Management and Information Technology

All of the policy papers suggest that improvements to information management and information technology will support improvements in patient care. Resident Doctors of BC strongly supports improvements in IMIT and believes that residents and early-career physicians need to be involved in the development and implementation of this technology.

Residents and early-career physicians are key populations of physicians likely to embrace new technology and can provide valuable insight into the use of different systems and applications in their intended practices. They are also uniquely positioned to provide insight into electronic access to patient information, as they work in dozens of health care settings across multiple health authorities over the course of their training.

Electronic Medical Records

The policy paper on IMIT focuses on integrated clinical systems that connect health information systems across the continuum of care: this includes Electronic Medical Records (EMRs) and standardized integrated administrative functions such as referrals, scheduling, and registration. If implemented, this technology would support the larger goal of creating multi-disciplinary practices and shared care. Residents believe that IMIT innovation would also facilitate moving services currently provided in hospitals to the community, as it would allow for improved communication and information sharing between health care providers. By allowing for rapid and easy access to health records, it may also have the added benefit of reducing redundancy in investigations and treatment.
The paper also proposes the creation of a single health record. Residents were in agreement that an interoperable centralized patient medical record is invaluable to the provision of high quality patient care, both in the in-patient and community setting. Resident doctors feel strongly that the standard of care for every patient should be that their health care provider has rapid 24/7 access to their complete medical record. Resident Doctors of BC calls for a safe and efficient province-wide system that can be accessed by care providers anywhere in the province for updated patient information, regardless of where the patient has been cared for previously.

Our members identified the need for widespread consultation of front-line users in the development and implementation of a centralized patient medical record. Particularly given the recent setbacks in implementing an electronic medical record at Nanaimo Regional General Hospital, it cannot be overstated how important it is to involve front-line clinicians, including resident doctors and practicing physicians, in the development and renewal of such a record, in order to ensure it is demonstrably safe and efficient.

The strong support for a centralized patient medical record among residents is based on the challenges they have faced accessing patient information while working in hospitals and clinics across BC. Residents are one of the few health care providers who rotate through multiple hospitals and clinics each year as part of their training. Residents discussed the difficulty of accessing information for patients treated at facilities within driving distance, but in different health authorities. For example, Vancouver General Hospital, which is part of Vancouver Coastal Health, and Burnaby General Hospital, which is part of Fraser Health, do not share an EMR and are not connected by a centralized patient medical record. As a result, patients treated at Burnaby General Hospital do not have their records available for easy access if they later
receive care at Vancouver General Hospital, even though the two facilities are less than ten kilometers from each other.

The creation of the Provincial EHealth Viewer (or “CareConnect”) has been an attempt to facilitate medical record access between different sites. While in its present form it does not constitute a single health record for the province, physicians working in Vancouver Coastal Health and Providence Health Care are able to circumvent the problem of separate EMRs by accessing this system. CareConnect is also valuable because it hosts some lab results from outpatient provincial laboratories. However, anecdotally, many hospital- and community-based physicians (particularly those based outside of Vancouver) are not aware of the system nor do they have access to it. Therefore, while a hospital-based physician in Fraser Health can access information about care provided in Vancouver through CareConnect, this is rarely done in practice due to barriers such as lack of knowledge about the system, difficulty obtaining access, and system efficiency.

While CareConnect is a valuable model, significant work needs to be done to either improve the system or to integrate it into a new centralized patient medical record. Work needs to be done to expand the centralized patient medical record to all hospitals in the province, to introduce access to community physicians, to guarantee that it includes imaging and investigations from private labs, and to ensure widespread physician education and access.
Recommendations

1. Develop an interoperable centralized patient medical record that is accessible from all clinical settings in British Columbia. The record should include all clinical information (labs, imaging, reports, prescriptions, etc.) about a patient, regardless of where it was originally collected. The record should be easily accessible for hospital and community physicians without significant time or cost barriers.

2. Provide education and training for all physicians around the centralized medical record to ensure widespread adoption.

3. Engage residents and early-career physicians in the development and implementation of the centralized medical record.

Telehealth

The expansion of telehealth is also discussed in the IMIT paper; the Ministry is seeking to standardize and expand telehealth particularly for rural and remote settings. Our survey results suggest that this would be an effective way to address physician burnout. Residents also felt it would assist with rural recruitment and retention, given that a commonly stated barrier is reduced access to specialist consultation and support.
**Recommendations**

1. Continue the expansion of telehealth services, with the objective of improving health care for patients in rural and remote settings.

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7. Conclusion

Resident Doctors of BC would like to thank the Ministry of Health for the opportunity to participate in the discussion of the initiatives proposed in the policy papers and to reiterate that the success of these innovations will depend upon the continued involvement of multiple stakeholders in development and implementation. We are confident that the necessary structures for change implementation will provide a meaningful voice to resident doctors, and we look forward to working with the Ministry to collaboratively implement the changes that will most benefit health care in BC.