Hybrid Model of Care Implementation Playbook

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Note: This document remains subject to revisions and updates as it is responsive to new information emerging from ongoing efforts and developments at sites across the province of British Columbia.

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Contact info and acknowledgements

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- Digital Health Canada
- Albera Health Services
- Saskatchewan Health Authority
- Ontario Health Services
- Nova Scotia Health
- Newfoundland & Labrador Health Services
- Health PEI
- Horizon Health New Brunswick

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Glossary

The following table outlines key acronyms and terms used throughout this document.

Acronym/Term	Definition
PVH	Provincial Virtual Health
PHSA	Provincial Health Services Authority
HMOC	Hybrid Model of Care
PIA	Privacy Impact Assessment
STRA	Security Threat and Risk Assessment
MoH	Ministry of Health
ECBC	Emergency Care BC

Introduction

This implementation playbook is a practical reference for hospital executives, decision-makers, project leads, and key partners involved in planning and implementation of Hybrid Models of Care within emergency, inpatient, and urgent primary care settings. It outlines key steps, processes and considerations from intake to sustainment and should be read in conjunction with the ***Provincial Hybrid Model of Care Guideline***.

Developed by Provincial Virtual Health (PVH) at the Provincial Health Services Authority (PHSA) in collaboration with subject matter experts, the playbook compiles lessons learned, best practices, and supporting tools from pilot sites and health authority partners. Each section aligns with a phase of HMOC implementation, with links to supporting templates/documents.

Background & description

Rural & remote hospitals within the province of British Columbia are experiencing physician coverage shortages leading to service disruptions in Emergency Departments, Inpatient Units, and Urgent Primary Care Centres. Current mitigation strategies including securing in-person locums for inpatient and ED physician coverage, while seeking long-term recruitment to fill vacancies are not sufficient to reduce risk of service interruptions.

The Ministry of Health (MOH), Emergency Care BC, Provincial Virtual Health (Provincial Health Services Authority [PHSA]), Rural Coordination Centre of BC, and regional health authorities have collaborated to develop a Hybrid Model of Care (HMOC) to help address the critical challenge of physician shortages and service disruptions across the province. Hybrid Model of Care (HMOC) involves integrating virtual physicians into in-person care teams to collaboratively manage patient care in in-person care settings.

HMOC aims to support and stabilize hospital operations, enhance access to consistent, timely care in acute settings and reduce strain on in-person staff, thereby mitigating burnout by incorporating additional physician support into a hospital. This model of care is not meant to *replace* in-person care; in-person provider coverage should always be prioritized whenever possible. However, virtual providers can serve as a valuable resource to *bolster* the on-site team's capacity and prevent service interruptions when an in-person provider is unavailable. Virtual physicians maintain access to all existing local and provincial resources. All existing on-site services are accessible to patients in hospital.

Hospitals across the country have implemented HMOC, successfully providing appropriate levels of care to their patients with the support of virtual physicians. Refer to HMOC Jurisdictional Scan April 2025 (Access to this resource is available by contacting Robyn Emde at robyn.emde@phsa.ca) for examples of models of care within Canada and additional information on the components described.
HMOC is intended to be adapted to the needs and nuances of the specific geographic region and/or specific site(s) in which it is implemented. The model has been piloted at several sites across BC's North and Interior regions. Insights from these pilots, The Provincial HMOC Advisory committee and colleagues implementing similar models across Canada have informed a comprehensive provincial framework and supporting resources, offering a replicable solution for other health authorities facing similar challenges.

Indigenous Recommendations for HMOC

The Hybrid Model of Care project has a primary focus on small to mid-sized rural and remote hospitals. Demographics of rural and remote regions tend to have high representation of Indigenous communities and as such Indigenous patients may experience a greater impact to rural and remote hospital service disruptions and delayed care. MOH and PHSA (including Emergency Care BC and Provincial Virtual Health) are guided by the HSO 75000 British Columbia Cultural Safety and Humility Standard. The standard helps governing body members and organizational leaders identify, measure, and achieve culturally safe systems and services that better respond to the health and wellness priorities of First Nations, Métis, and Inuit peoples and communities, regardless of where they are located. The Hybrid Model of Care project incorporates learning from such reports as well as engagement with key partners. Supporting documentation are significant reports pertaining to Indigenous-specific racism and/or discrimination as well as truth and reconciliation. The In Plain Sight Report (2020) addresses health care discrimination and is a critical pillar to the work being done in a good way. Other foundational documents to consider include Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). The Truth and Reconciliation Commission of Canada Calls to Action (Truth and Reconciliation Commission of Canada, 2015a). These do not include Host Nation Memorandum of Understandings that may exist, nor do they exhaust all documents. Metis, Urban and Away Indigenous Peoples also should be included.

*Refer to the **HMOC Guideline** for more information.*

Overview of the HMOC framework

The decision to implement HMOC for clinical operations is owned and operated by each regional health authority. At the same time, provincial consistency should exist across HMOC policy & standards,

guideline, education and training, reporting & evaluation, and resource prioritization. *Refer to the **HMOC Guideline** for more information.*

Note: The following sections outline an ideal order of events to initiate and plan the project. Not all activities may apply, and/or the order of activities may differ.

Section 1: Intake and assessment

Identify site(s) for potential virtual support

The intake and assessment process begins by identifying one or more hospital sites within your health authority that may benefit from virtual support via a Hybrid Model of Care.

Readiness assessment

Evaluate each site and its surrounding community for readiness by examining current challenges, reviewing available data, assessing openness to change, and determining the feasibility of launching a pilot.

Refer to Appendix A: HMOC Readiness Checklist.

Service model exploration

Before forming a full project team, explore potential service models that address the identified clinical challenges. This step helps clarify the future-state vision and informs project planning.

For detailed approaches, see Section 3: Project Planning in this document (HMOC Implementation Playbook)

Section 2: Project initiation & engagement

Governance

It is recommended that each site/health authority have a governance structure for the planning and implementation of a Hybrid Model of Care within their health organization. Each new HMOC site should have a connection to share progress to date and lessons learned back to the Provincial HMOC governance table.

Project team

The following roles are recommended to ensure that project activities are completed effectively, and that appropriate guidance is available throughout implementation.

Role	Recommended Individual(s) *
Co-Chair(s)	Executive Director, Director level, including operations leadership
Project Lead	Manager or Senior Project Manager
Project Manager(s)	Project Managers: Clinical operations and virtual/digital health
Project Team	Ensure representation for the following knowledge areas: • Clinical Operations (Emergency and Inpatient) • Technology • Privacy and Security • Evaluations • Project Management • Change Management • Communications • Professional Practice • Indigenous Care

**Note: Roles, titles, and group member identification is up to the discretion of the health authority/ site.*

Working groups & deliverables

Once the site or regional service model has been determined and funding is secured, form working groups to contribute expertise and co-develop the systems and workflows needed to support the hybrid model of care.

Role	Recommended Individual(s) *
Working Group Leads (As necessary)	Directors or Managers in the following departments/teams: • Clinical (Operations) • Technology (Digital) • Evaluation • Resourcing/Training (HR, Education) • Physician Contracts • Change Management/Communications/Planning
Working Group Members (As necessary)	Subject Matter Experts from: • Clinical (Operations) • Technology (Digital) • Evaluation • Resourcing/Training (HR, Education) • Physician Contracts • Change Management • Communications • Indigenous Care • Physician Representative/s

**Note: Roles, titles, and group member identification is up to the discretion of the health authority/ site.*

The HMOC Site Implementation Checklist & Working Group Deliverables, which outlines detailed description of each working group and their deliverables, is available by contacting Robyn Emde at

robyn.emde@phsa.ca. Use this checklist as a starting point to tailor to the unique needs of your project.

Change management

To inform work and support the change management for this project, it is recommended to leverage **Prosci's ADKAR model**. This model provides a practical approach to change management and has been beneficial for identifying the appropriate activities to engage in at each phase of the project.

Refer to Appendix I: Application of ADKAR Change Management Model for Hybrid Model of Care Implementation at Pilot Site #1

*Template: **Key change management considerations and activities** for any HMOC project can be accessed by contacting Robyn Emde at robyn.emde@phsa.ca.*

Key partner engagement

Engaging partners enables the project team to co-create the model of care with those who will be working directly with it. This ensures that key perspectives and information can be included in the project, supports buy-in, and change management, and ultimately leads to a more successful implementation. The appropriate partners to engage when implementing a Hybrid Model of Care will vary by site, community, and region.

When to engage

Engage with key partners begin as soon as possible to allow relationships to begin to develop and to provide as much of an opportunity for partners to be involved in the planning and implementation of the project as possible.
Example: Using a model of co-creation with partners at **Pilot Site #1** has been beneficial for developing accountability and creating momentum.

Who and how to engage

Physician Engagement: Physicians provide critical clinical and operational insight that directly shapes how the Hybrid Model of Care functions in practice. Early engagement of both local and regional physicians is strongly recommended to ensure relevance, buy-in, and sustainability.
Identify a physician site champion to participate in working groups and take ownership of clinical leadership throughout the development and implementation process. Their involvement helps guide decision-making, foster peer engagement, and support successful integration of the model into practice.

Clinician Engagement: Clinicians at the site who will be involved and impacted by the implementation of a Hybrid Model of Care. This includes but is not limited to physicians, nursing, pharmacy, diagnostic imaging, rehabilitation, discharge planners etc.

Staff Engagement (Hospital Support Staff): Non-clinical staff at the site who will be impacted by the implementation of a Hybrid Model of Care. This includes, but is not limited to: Hospital leadership, administration, unit clerks etc.

Patient Partner Engagement: Engaging patients who live in the community or have experience receiving care at the site is essential to ensuring the Hybrid Model of Care reflects local needs and values. Connect with your site or health authority's patient engagement team to learn about the process, best practices, and required documentation.

- Assign a dedicated point person from the Core Project Team, such as a project manager or Indigenous care lead, to coordinate patient partner engagement and communication.
- Clearly communicate honorarium details and track them from the outset of engagement.
- Orient patient partners to the project, ensure confidentiality agreements are in place, and provide briefing before and debriefing after each engagement activity.
- Prioritize respectful, inclusive, and culturally safe engagement practices, especially when working with Indigenous patient partners.

Indigenous Partner Engagement:

- Local nations with members who have previously/would likely visit the site and/or who live in the community are ideal to engage.
- Local nations may have an individual/team assigned to healthcare project engagements. Many Indigenous communities have their own relationships with local hospitals and Health Authorities, outside of FNHA, federal programs or other secondary connections.
- There is likely Health Director for the Health Unit for each local Indigenous community within the region. Health Directors are typically aware of their community's usage of local and nearby healthcare services and can identify the needs of the Local Health Department in supporting the community. Health Directors can also often identify local community members or health hubs, e.g., nurses or social workers working in the community, who are available for engagement. Note: Health Directors may not be Indigenous and the position may have a high turnover rate.
- Indigenous Patient Navigator or Indigenous Engagement Team from involved hospital(s) or Health Authority.
- First Nations Health Authority representatives, as appropriate (depending on the relationship in the region)

Engagement Activities

There are various modes and strategies to employ when engaging with partners. A key engagement decision is the mode in which you will engage partners: virtually or in person. The mode you choose should depend on the objective(s) you are trying to achieve, the stage of change you are in *(see Prosci ADKAR change model),* and should take into consideration the availability, location, accessibility needs, and preferences of your partners.

Examples of engagement strategies include:

- Hosting a project kick-off
- Hosting a townhall
- Presenting at a recurring daily/weekly/monthly meeting
- Organizing drop in office hours
- Send out a survey
- Organizing interviews for staff engagement and utilization in staff and/or public facing communication materials

- Organizing focus groups
- Organizing feedback boxes at the site
- Posting information on a whiteboard at the site
- Including a blurb in a staff newsletter or similar communication
- Identifying a point person on site who can answer questions and receive feedback

Example: Engagement activities at Pilot Site #1

General Engagement:

- Virtual engagement: A virtual kick off with leadership, providers, and the project team took place to level set on the current state at Pilot Site #1, to learn more about different models of care from experts across the country, and to generate hope and enthusiasm.
- In person engagement: An in-person Innovation Day with leadership, providers, patients, indigenous partners, and the project team took place where attendees were able to "Explore, Evaluate, and Envision" virtual care. Participants explored the current state at Pilot Site #1, evaluated models of care from examples across the country, and envisioned what a model of care might look like for Pilot Site #1.
- Site visits: any site visit in preparation for pilot launch is an opportunity for engagement. Bringing staff together formally or informally to co-develop the service model, discuss the project status, get feedback, encouraging participation in site assessments and training fosters ownership over the project from the clinical staff.

Indigenous Engagement:

An engagement plan with local indigenous communities was created for the pilot at Pilot Site #1. The following were the key activities:

- Ensured Indigenous Elders and representatives from the local community were invited to all engagement sessions.
- Ensured cultural practices, such as gift giving, for Elders were honoured and coordinated ahead of each engagement.
- Ensured honorariums were available and coordinated for Indigenous Elders and/or community leaders that participated in each engagement.
- Recruited and involved patient partners who self-identified as Indigenous, and ensuring they were paid for their time and contributions.
- Promoted open dialogue and feedback via face-to-face meetings and regular communication with local Indigenous community leaders.
- Considered cultural representation for all monitoring and evaluation activities.
- Ensured land acknowledgements were included at the beginning of all meetings and engagements.
- Encouraged all employees on the project team have taken the San'yas Indigenous Cultural Safety training.
- Considered First Nations Leadership in the community have an opportunity to hear and provide insights on the care model being tested and training provided to hospital staff (in person and virtual)
- Share community FAQs with First Nations leadership for feedback and learning
- Provide a channel for direct feedback from First Nations communities to the hospital

Communications

Communicating about the project with impacted partners and groups is equally as important for the success of the project as completing the project deliverables. Key aspects of the communications plan were as follows:

- Communications plan
- External news briefing
- Key messages
- Q&A
- Patient facing pamphlet and poster
- Nursing script to explain virtual services

Refer to templates: Communications templates
(Access to these resources are available by contacting Robyn Emde at robyn.emde@phsa.ca)

NOTE: White labeling the vendor's name to the public is preferable. Should the vendor change, the communication materials will not have to change to align with that. Remember, this is the health authority providing this service and the vendor is one piece of that.

Section 3: Project planning

This section outlines the foundational elements required to design a service model that meets the unique needs of each site, including clinical workflows, team roles, technology infrastructure, and escalation protocols. Through collaborative planning with local partners, including clinicians, Indigenous partners, and operational teams, this phase ensures that the hybrid care model is tailored to the community context while maintaining provincial standards. The goal is to build a resilient, patient-centered system that supports safe, equitable, and efficient care delivery.

Service model development

Service model development should be informed by engagement and data analysis on the problem that needs to be solved, as outlined above and in the **HMOC Guideline.**

Based on readiness activities, the following service streams can be considered:

Service	Shift	Service Model	Driver/Problem to Solve	Staffing Support
Emergency Department	Daytime	**Hybrid On-Site** (workload augmentation) *Or* **Hybrid On-Call**	• Service interruptions due to reduced physician capacity onsite • Long waitlists • Patients left without being seen • Ad hoc daytime coverage needed due to physician sick calls/vacation	• Virtual operations team • Onsite team
	Overnight	**Hybrid On-Call**	• Long waitlists • Patients left without being seen • Service interruptions due to reduced physician capacity onsite	• Virtual operations team • Onsite team

Service	Shift	Service Model	Driver/Problem to Solve	Staffing Support
			• Proactive overnight coverage alignment with Corridors of Care work • Ad hoc overnight coverage needed due to physician sick calls/vacation	• Resting in-person physician
Inpatient Unit	Daytime	**Hybrid On-Site** (workload augmentation) or **Hybrid On-Call**	• Service interruptions due to reduced physician capacity onsite	• Virtual operations team • Onsite team • Escalation pathway to in-person physician
Primary Care (low acuity)	Daytime	**Hybrid On-Site** **Hybrid On-Call** **Fully Virtual**	• Long waitlists • Service interruptions due to physician shortage • Ad hoc coverage needed due to physician sick calls/vacation. • Increased ED volumes due to lack of primary care	• Virtual operations team • Onsite nursing team • Hands on assessment deferral or escalation protocol

Core HMOC team roles and responsibilities

To implement a successful hybrid model of care, relationships between virtual and onsite staff are critical. This model of care requires a team around the virtual physician and patient for their care interaction; it is recommended to have the following staffing model:

Virtual Team

- **Virtual Provider:** Assigned as MRP for cohort of patients. Responsible for clinical assessment and decision-making, collaboration with on-site teams, referrals and diagnostics, documentation, alignment with in-person MRP coverage and/or handover.
- **Virtual Clinical Support Staff:** Supports the virtual physician as needed. Key point of contact for questions and queries for the on-site hospital staff and can have a role in ensuring patient information transfer is efficient and timely, and physician orders are followed up.
- **Virtual Operations Team:** Responsible for virtual provider scheduling, site intake, evaluation, virtual provider training and performance management, and technology support.
  May work with the virtual clinical support staff to ensure patient information transfer, submitting orders, patient record management, and patient result follow up.

Onsite Team

- **On-site nurse or delegate:** The on-site nurse or designated delegate (e.g., LPN, resident, physician's assistant) is responsible for facilitating the virtual physician's connection with the patient. They ensure patient confidentiality during the consultation and assist with operating any necessary peripherals (e.g., stethoscope) to enable the provider to properly assess the

patient. They are tasked with completing any required assessments on behalf of the provider during the virtual consultation.

- **On-site or On-Call Provider:** Provide care for patients who require hands-on assessment. On-site provider is responsible to follow-up with the virtual provider for any patient handover or shift changes.
- **On-site leadership:** Provide support to onsite clinical and clerical team.
    - Coordinate virtual and in-person care delivery
    - Schedule team huddles
    - Lead quality improvement initiatives
    - May need to advocate for a temporary increase in staffing to support the integration of virtual care workflows
- **On-site allied health staff**: support the care journey of the patient & family, require awareness to HMOC workflows.
- **On-site Indigenous patient navigation:** Access to Indigenous patient navigators available to Indigenous patients onsite.
- **On-site administrative/clerical staff:** support information transfer between the unit and the virtual physician, and vice versa.

Virtual operations team & support composition

The following roles are recommended for the virtual clinical support and operations team:
1 operational team can operate up to 5 sites with 1 additional nurse (nursing may increase depending on site volumes and virtual physician needs)

Role Type	Responsibility
Operations Team	
Director	Provides strategic oversight, ensures alignment with across the health authority, and secures executive support and resources.
Manager	Oversees day-to-day operations, coordinates across teams, and ensures timelines and deliverables are met.
Coordinator	Manages logistics, scheduling, communication between clinical and operational teams to keep implementation on track.
Clinical nurse	Supports virtual physician & frontline teams day-to day with information flow, ordering, and follow up; supports frontline team with training and quality assurance.
Support services	
Technology Support	Provides technical assistance for virtual care platforms, troubleshoots technology issues, contributes to staff training around use of technology.
Legal	Reviews contracts, privacy, liability issues to ensure compliance with provincial and/or regional regulations and virtual care standards.
Finance	Manages budgeting, cost tracking, and funding allocations to support sustainable implementation.
Communications	Develops internal and external messaging to support partner engagement, change management, and public awareness.

Other Admin	Provides essential administrative functions such as documentation, scheduling, and coordination across departments and sites.

Fostering interprofessional collaboration in a hybrid environment

Trust and rapport between physicians, nursing, and the other members of a patient's care journey is well documented to enhance care outcomes, improve efficiency, and is the foundation of a quality care experience. This takes some time to be established for in-person teams; however, can take longer for a virtual physician as they are not in the physical location as the rest of the team. It is critical to pay attention and create an environment where trust can grow.

1. Establish Clear Roles and Responsibilities

- Define each team member's role explicitly in the virtual care setting.
- Use shared digital tools (e.g., collaborative care plans) accessible to all team members.
- Clarify who is responsible for technology setup, patient follow-ups, and documentation.

2. Enhance Virtual Communication

- Use secure, user-friendly platforms approved by BC health authorities.
- Adopt structured communication tools (e.g., SBAR – Situation, Background, Assessment, Recommendation) adapted for virtual use. *See Appendix D: SBAR communication template.*
- Schedule regular virtual team huddles to discuss patient care and team coordination. *See Appendix E: Virtual care huddle template HMOC teams*
- Encourage active listening and confirm understanding to reduce miscommunication.

3. Promote Cultural Safety and Sensitivity

- Recognize and respect cultural differences amplified in virtual interactions.
- Provide training on virtual cultural competence for all team members.
- Use interpreters and culturally appropriate resources when needed.
- Create a welcoming virtual environment that respects patient identity and preferences.

4. Build Virtual Team Cohesion and Trust

- Foster openness and psychological safety during virtual meetings.
- Use video calls where possible to enhance non-verbal communication.
- Encourage informal check-ins to maintain relationships beyond clinical discussions.

5. Address Conflict Proactively

- Establish clear protocols for resolving conflicts in virtual settings.
- Encourage early identification and transparent discussion of disagreements.
- Use mediation or escalation pathways when necessary to maintain team harmony.

6. Ensure Privacy and Security

- Follow BC regional health authority guidelines for virtual care privacy and security.
- Use encrypted communications and password-protected devices.
- Educate patients and team members about privacy practices in virtual care.

. Engage Patients and Families Effectively

- Prepare patients for virtual visits, including technology checks and privacy considerations.
- Encourage patient and family participation in virtual team meetings when appropriate.
- Use clear, jargon-free language and verify patient understanding frequently.

8. Leverage Technology Competently

- Provide training for all team members on the virtual care platforms and tools used.
- Designate a technology support lead within the team.

- Ensure backup plans for technical failures (e.g., switching to phone calls).

9. Continuous Learning and Improvement

- Collect feedback from patients and team members on virtual care experiences.
- Reflect regularly on team processes and outcomes to identify improvement areas.
- Stay updated on emerging virtual care best practices and technologies.

Enabling technology

Technology considerations

A technology solution for a hybrid model of care service model is required for a fulsome care experience between the physician and the patient. A list of recommended considerations can be found in the **HMOC Guideline.** A full list of clinical and technical requirements can be accessed by contacting Robyn Emde at robyn.emde@phsa.ca.

Privacy considerations

It is important to engage your regional privacy and security teams early to allow sufficient time for Privacy Impact Assessment (PIA) and security (STRA) approvals to take place.

Guidance to support clinicians and staff to best ensure privacy and communicate information about hybrid model of care services to patients and their families can be found in the **HMOC Guideline.**

The following resources are available to support patient privacy & consent (Access to these resources is available by contacting Robyn Emde at robyn.emde@phsa.ca):

- For an example patient consent script see: Provider to patient consent to virtual care script
- For an example patient information brochure see: Virtual Care Pamphlet

Workflow mapping

Integrating virtual physicians into onsite clinical environments will require careful consideration and unique workflows for each new site/clinical service. The following are recommended processes to guide implementing a hybrid model of care:

Team Engagement:

- Co-creation of the hybrid model of care service design
    - Engage staff on their current state challenges and which service model would best fit the problems they are needing to solve clinically and the technology solution to fit.
- Workflow co-design
    - Involve staff to co-design the workflows and cut over processes to integrating the hybrid model of care into their work
- Implementation support
    - Provide clear and easy to use implementation pathways and ensure quick access to support (clinical and/or technological) is available.

- Involve staff in any soft launch or testing to incorporate real time feedback

Prior to determining the future state for a site, current state must be known. Once current state is validated with the onsite team, the future service model can be mapped in a future state workflow. This is a wonderful opportunity to understand the current realities of staff and co-create the future with them.

Map current state workflow for the department

The current state workflow should include all key components from start to finish of the patient journey and staff activities in care provision in the department. This includes: Arrival, Registration, Patient List/Waiting List, Triage, Intake, Admission, Assessment, Orders, Rounding, Documentation, Follow up, Handover, Discharge, Escalation. All tools and systems used for each individual action including how communication happens between different individuals should be indicated including Telephone, EMR system, etc.

Refer to: HMOC Workflow Examples (Access to this resource is available by contacting Robyn Emde at robyn.emde@phsa.ca)

Map future state workflow for the department

Develop future state workflow in collaboration with vendor and the following functions, at a minimum: clinical operations, clinical informatics, IMIT, & a physician delegate. This will include identifying clinical, technical and operational questions and requirements for addressing to implement the proposed service model. These considerations are developed and addressed in collaboration with the vendor if applicable.

The future state workflow will aim to include the virtual services, customized to align with existing requirements of each site. It will include existing clinical procedures such as:

- Virtual physician practice
- Patient assignment to virtual care
- Patient transfer to a higher level of care
- Integration of virtual coordination team
- Shift to Shift hand over
- Managing emergencies/escalations
- Lab/diagnostic imaging results follow-up
- Complaints investigations
- Downtime process
- Physician to physician consult
- In-hospital death
- Meetings with patient's family or other supporting individuals

Considerations include:

- Providers' coverage shift schedule structure and back-up plans/escalation processes
- Criteria and guidelines for patients being seen virtually
- Informing patients of the virtual service and receiving consent and information privacy implications of sharing personal information with third-party vendor, see
- Equipment and systems
- Credentialling, privileging, access and provisioning
- Provide an opportunity for consultation from all care providers who will touch that patient journey directly or indirectly (ex. Pharmacy, Physiotherapy, Occupational Therapy, Patient Care Coordinator, Discharge Coordinators, Indigenous Care Liaison etc.)

Patient assignment for virtual care

Establishing patient assignment criteria for virtual care is a critical next step to planning the launch of hybrid model of care. These criteria will help define which patients are appropriate for virtual physician support, ensuring safe, consistent, and high-quality care across sites. Clear guidelines will support clinical decision-making, align virtual workflows with in-person care, and reduce variability in practice. They also help mitigate risks, promote provider confidence, promote hybrid team collaboration, and ensure that virtual care is used effectively. Access to the resources listed below is available by contacting Robyn Emde at robyn.emde@phsa.ca.

- For the Emergency Department, a tool by Emergency Care BC has been endorsed: ED Virtual Care Patient Assignment Tool
- For the Inpatient Department, a tool has been developed by Pilot Site #1: Inpatient Unit Patient Assignment Decision Support tool
- For Primary Care, a tool has been developed by the Virtual Primary Care team at Interior Health: Virtual Primary Care Guideline - Patient Assignment

Escalation Protocols

A clear escalation protocol empowers staff to respond quickly and appropriately to urgent or deteriorating patient situations in virtual care settings. It ensures patient safety, minimizes delays in care, supports clinical decision-making, and fosters confidence among providers by outlining roles, responsibilities, and communication pathways.

- Ensure all staff (virtual and in person) know how to escalate issues and concerns
- Ensure transport pathways are clear if patients need to access to higher level of care
- Refer to: HMOC Virtual Acute Care Escalation Process (Access to this resource is available by contacting Robyn Emde at robyn.emde@phsa.ca)

Language, equity, and access

To ensure equitable access to virtual health services, language accessibility must be prioritized and planned for.

Consider the following:

- Interpretation services via Provincial Language Services are included in any workflow designed to support 24/7 access qualified interpreters by phone or video.
- Testing remote interpretation services with the technology solution selected for HMOC
- Provide training to providers, patients, and families on how to access and use language services in a virtual care scenario
- For more details on accessing Provincial Language Services, *see Appendix H: Accessing Provincial Language Services*

Training and education

Developing a training and education plan

Education and training plans are required for all personnel who interact with the patient journey, as well as the patients themselves. A level of readiness to understand what hybrid care is and ability to provide informed consent on this new service model is essential for patients. For staff, a level of readiness to implement services is required, but also to support the patient through their hybrid care experience with confidence. It is important for virtual providers to not only be able to deliver safe and effective care but also understand the local context of the site and community is which they are providing services.

The Provincial HMOC Education Framework to support virtual providers, onsite staff (including nursing, allied health, admin, and leadership), and patients & families can be found in *Appendix A: Provincial HMOC education framework.* The intention of this framework is to provide minimum standard of training and base content for a site to develop their own site-specific training from.

Evaluation planning

Health authorities are responsible for developing a comprehensive evaluation plan aligned with the Provincial HMOC evaluation framework for quality assurance. The evaluation framework is aligned with the Quintuple Aim, Health Quality BC Dimensions of Quality, Ministry of Health reporting requirements, and Indigenous Specific Anti-Racism (ISAR) principles.

To support transparency and build a provincial baseline, each site or health authority should share data with the provincial team as it becomes available. All data will be combined for consistent provincial monitoring. Health authorities must collect both standard provincial metrics, and any additional data based on local needs. Health authorities are responsible for providing the Ministry of Health, or its delegate, with data upon request. *See Appendix F: Provincial Evaluation Framework.*

Section 4: Implementation preparation including site visit(s)

Preparing for implementation involves translating the service model into practice through coordinated site visits, staff engagement, and operational readiness activities. This section provides guidance on planning and executing site visits, training sessions, and pilot launch preparations. It emphasizes the importance of change management, communication, and support planning to ensure frontline staff are

informed, equipped, and confident in delivering hybrid care. By fostering collaboration between health authorities, vendors (if applicable), and site teams, this phase lays the groundwork for a smooth transition to virtual-integrated services.

Planning virtual engagements and site visits

Engagements with staff at the site is critical for change management and to ensure they feel informed and included on planning for the virtual services which will be impacting their work. These engagements must be planned and executed with an agenda, appropriate speakers, relevant content, including anticipating questions which may arise and being proactive to answer them, and opportunities to solicit feedback.

Pilot kick off

Consider holding a Kick-Off event that introduces the pilot, the vendor if applicable, and what clinical/operational teams can expect as part of the pilot. It is recommended to hold this prior to the HMOC project team visiting the site OR in the welcome presentation of the new model of care to ensure all staff have awareness of all activities leading up to the pilot.

Site visits

In preparation for launching HMOC, several site visits are recommended. These site visits support the set-up and preparation of the solution and related workflows, ensure the technology is calibrated to the site, training and simulations for staff, and a soft launch of the virtual workflow prior to pilot launch. Site Information Technology representatives should also be present to ensure connectivity at the site is optimized for the technology required for the service.

Site visit 1: Site assessment

In preparation for site visit 1, develop an agenda and plan that details the activities and requirements for the site visit.
Consider the following:

- Initial assessment of site for device optimization to ensure the networks and the devices are connected and working correctly on site.
- Site walk-through to validate *current* state workflows. This will include shadowing physician and nursing team to understand day to day patient care and workflow.
- Development/optimization of future state workflows, using Service Design *developed as part of Planning phase.* This will include simulation and validation.
- Open House / Drop in / “Meet and Greet” with Vendor (if applicable) and/or team implementing solution. Consider including video and or live demo of the technology

Consider the following attendees to site visit 1:

- Site staff:
    - Nursing Leadership: Clinical Manager, Patient Care Coordinators (Charge Nurses) x2, Nursing educator, Nursing union rep
    - Floor Nurses ad hoc (drop-in)
- Physician reps (drop in as able):

    - Hospitalist/ED physician
    - Chief of Staff
- Leadership:
    - Site Director of Operations
    - Executive Director of the region
- Broader Health Authority support team: Digital Health and Clinical Informatics (physician support specialist), Quality & Improvement Rep, Communications
- Provincial Virtual Health (PHSA)
- Vendor

Site Visit 2: Training and soft launch

Consider including the following activities:

- Technology "testing" and training kick-off; on-site staff try out, and demo technology/ Short on-screen demo of the virtual care platform and capabilities
- Test system and process in dry run, refine and revise systems as needed.
- Training simulations and soft launch of the HMOC workflows. Prior to pilot launch, leverage the experience of patient partners, including indigenous patient partners, in training for real time feedback about their experience is an option for optimal engagement

Site champions

Site champions are onsite staff and leadership who are onboarded as change champions. These are the people who work on the site, who can be there to answer questions, and be enthusiastic about this new service and change. It is crucial to prepare these people formally to ensure they know their role and who to ask for support when they get faced with questions from staff.

Refer to: Site champions (Access to this resource is available by contacting Robyn Emde at robyn.emde@phsa.ca)

Orientation

Conduct an orientation huddle with this group during site visit #2 (prior to launch), this includes:

- Provide an overview of planned soft launch and launch for the pilot
- Overview of their role and expectations of site champions
- Overview of who they go to for support and how they should access that
- Opportunity for questions and discussion

Materials/Content

Prepare to have these on hand:

- Q & A about the service
- Escalation pathway document

- Patient brochure and poster
- Nurse script
- Provide t-shirts to wear during site visit 2 and during the pilot launch to make them easily identifiable

Onsite information booth

The hospital will be full of staff who don't require direct training but will intersect with the patient journey and could benefit from knowledge of the new service. To provide awareness and knowledge for those staff members (i.e. physicians on other service lines, allied health professionals, patient navigators, discharge coordinators, food services etc.) and information booth set up in a central location with information and a site champion to speak to the service is recommended.

Refer to: Site information booth (Access to this resource is available by contacting Robyn Emde at robyn.emde@phsa.ca)

Materials to support the information booth:

- Q&A about the service
- Patient brochure and poster
- Video illustrating the service

Indigenous Engagement to Prepare for Launch

Prepare the following for go-live:

- Provide updates in external facing communications, collaborate with local Host First Nations, Friendship Centre health reps, Metis BC community leadership to deliver the content as appropriate for all Indigenous members in the region.
- Create a framework for indigenous engagement in community as well as from community partnerships to ensure equitable feedback process within HMOC.
- Create a variety of feedback opportunities including surveys, community circles, sharing circles etc.
- Strategize a framework that ensures community protocols are respected and followed
- Integrate indigenous patient partners into PDSA cycles as appropriate
- Consider an indigenous protocol/ ceremony of the go live/pilot launch

HMOC risks and mitigation strategies

This table outlines key risks to consider prior to launch associated with virtual care implementation and provides corresponding mitigation strategies to support safe, effective, and sustainable deployment across healthcare settings.

Note: This is a representative list of common risks and mitigations, not a comprehensive inventory.

Risk	Mitigation Strategy
Disagreement among key partners or leadership	Facilitate early and ongoing partner engagement; use structured decision-making frameworks and consensus-building tools.

Risk	Mitigation Strategy
Limited clinical staff endorsement	Engage clinical champions early, this includes physicians, nurses, clerical staff, etc. Provide clear evidence of benefits and safety; offer training and feedback loops.
Insufficient local physician staffing	Use hybrid models with virtual physician support; coordinate with locum programs; explore shared regional coverage.
Technology requirements not met	Conduct early tech assessments; secure funding for upgrades; ensure vendor support and interoperability.
Technology useability challenges	Ensure all virtual care technology is connected, functioning properly, and that in-person staff are trained to use it to avoid delays in patient care.
Administrative barriers to system access	Streamline provisioning processes; establish clear protocols for access; engage IT and privacy teams early.
Distrust between virtual and in-person clinicians	Build trust through team huddles, joint case reviews, shared protocols, and regular communication; promote team-based care culture inclusive of physicians, nurses, allied health, and support staff.
Limited engagement with patient and Indigenous partners	Allocate dedicated resources for engagement; use culturally safe approaches; co-design with community representatives.
Increased diagnostic service demand to support virtual physician assessment	Monitor diagnostic utilization; adjust workflows; ensure capacity planning includes diagnostic services.
Increased nursing workload to support virtual physician assessment	Design workflows to balance tasks; provide support staff; monitor workload and adjust staffing as needed. Consider adequate nursing support to accompany the virtual physician.
Accessibility challenges	Confirm that accessibility supports—such as interpretation services and Indigenous patient navigation—are integrated into the care model.

Section 5: Pilot launch

Develop & initiate support plan

Initiate and activate site support plan for go-live, stabilization, and sustainment/optimization, see Appendix G:

- Purposefully have onsite leadership from support functions available for the pilot launch to support any issues/challenges in real time.
- Consider booking a conference room for support functions to operate out of as a "nerve centre" for launch. This ensures support functions are ready to support quickly, but not on the clinical floor/disrupting operations.
- Be prepared for changes and iterations to the service right from the start, this is normal and should be communicated to staff as such.

Site Support Materials

The following materials should be available at site (note: this list is not exhaustive, there may be site specific materials that are required):

- Transfer protocols, pathways, and contact information
- Escalation pathways
    - Higher level of care
    - Patient refuses virtual care
- Consultation pathways for specialists and contact information
- On-call physician contact (as needed)

Communications

- Receive and disseminate endorsement and communication of support from site/HA leadership (e.g. letter of endorsement from Vice President)
- Send out staff memo
- Prepare for media briefings
- Reach out to community partners re: the pilot launch and impact on the community, solicit feedback from various channels

Monitoring and evaluation

Following launch, it is important to monitor implementation closely to support ongoing quality improvement as well as plan for fulsome evaluation.

- Hold clinical workflow & staff experience discussions between 3-5 week to initiate PDSA cycles for workflow iterations, address challenges, and capitalize on efficiencies.

- Log all issues and decisions within the PDSA cycles, ensuring to assign ownership and actions for each.
- Complete PDSA cycles and document lessons learned, share back to the Provincial Hybrid Model of Care Committee.
- Activate data collection processes for values identified as part of provincial and local evaluation plan. *Refer to Appendix F: Provincial evaluation framework.*

Section 6: Pilot Conclusion and Sustainment

Pilot conclusion

- Conduct a debrief with project team about lessons learned
- Continue to hold regular debriefs with staff as a part of continuous improvement processes to reinforce the change
- Conduct a partner assessment of their experience and willingness to engage further
    a. Example: send out survey's, conduct interviews, and/or hold focus groups with clinicians and patients to hear their experience
- Once the pilot is considered in "sustainment", transfer ownership to operations via a series of meetings and/or written guides

Scalability

Scalability of HMOC requires thoughtful planning to ensure the model can be expanded across multiple sites while maintaining quality, safety, and consistency. Project teams must assess site readiness, staffing capacity, technology infrastructure, and workflow adaptability.
Key considerations include:

- standardizing core components (e.g., virtual provider roles, escalation protocols, training frameworks)
- ensuring interoperability of systems
- establishing governance structures that support both local autonomy and provincial coordination.
- ability to replicate successful service models, engage partners, and monitor outcomes to inform continuous improvement.

Resource prioritization

BC is faced with limited resources – funding and physicians, and organizations may need to prioritize where virtual support is provided.

A health authority may consider the following:

1. **System Need**: Response to immediate system pressures, patient volumes, history of service interruptions etc.

2. **Health Human Resource Impact:** Workforce stability and wellbeing.
3. **Equity & Access:** Ensure equitable access to care across all regions.
4. **Implementation Feasibility**: Overall site readiness, infrastructure availability, clinical support champions.

Appendix A: Readiness Checklist

Objective: To reflect on the preparedness of the healthcare site and local community for implementing a Hybrid Model of Care by identifying current challenges, analyzing existing data, assessing change needs

1. Current State and Needs Assessment

Purpose: Collect and analyze both quantitative and qualitative data for the site and region and identify current issues, downstream effects, and existing mitigation strategies to gain an objective understanding of the context.

A. Identify current state site and region details such as:

- Demographics: Population of area served, local Indigenous communities and number of Indigenous patients accessing services, % attached/unattached to primary care provider if relevant
- Distance patients are travelling to receive in person services
- Accessibility needs / language access, interpretation needs and translation services needed for equitable care
- Hospital capacity: number of beds etc.
- Hospital occupancy rate
- Alternative level of care (ALC)
- Patient demographics including % attached/unattached)
- Volumes: number of ED visits, number of admissions (annual and trends), admissions by time of day
- Number of ED visits by GP attachment if relevant
- CTAS levels: volumes and trends (volumes of each CTAs level and CTAS patterns throughout the day)

B. Identify details related to the issue/problem and related downstream effects such as:

- Physician and (if relevant) nursing position shortages/vacancy rates
- Physician and (if relevant) nursing shift vacancy rates
- Gaps in coverage across day vs. night shifts
- Number of shifts filled by locums in the last year (may also include comparison to previous years)
- How does the problem affect clinical services?
- What services stop or slow down?
- How does the problem affect patient care?
- How long has the problem been occurring for?

C. Identify current mitigation strategies to address challenges:

- What strategies are currently used; for example, reliance on locums, redeployment for other sites, recruitment strategies, scheduling adjustments?
- How successful have these strategies been? What are the ongoing challenges with these strategies?

2. Change Readiness

Purpose: Ensure readiness for implementing the Hybrid Model of Care by securing leadership support, assessing staff awareness and experience, evaluating resource capacity, and identifying change champions.

A. Confirm executive leadership awareness and endorsement to explore HMOC pilot and further define work of target clinical area.

B. Identify level of awareness of virtual care and/or hybrid models of care, desire, and knowledge and/or previous experience.

- Physicians
- Nursing staff
- Executive Leadership
- Operations and Clinical management
- Patients
- Allied health (for example, physiotherapy, occupational therapy, pharmacy, indigenous patient navigators, discharge coordinators etc.)
- Clerical
- Other key staffing groups as appropriate

C. Identify Health Authority/clinical site resource, budget, and capacity

- Confirm HA and site leads.
- Identify and confirm existing HA and site resources to support:
  - Executive lead
  - Operations lead
  - Clinical lead
  - Physician lead
  - Project Manager and project team
  - Administrative
  - Clinical education lead
- Change Management and Engagement
- Identify potential resources gaps/needs to begin change process (E.g., project management, clinical workflow mapping).
- Identify potential barriers and resource constraints to initiating and/or progressing this work.

D. Identify change champions.

- Look for (clinical operations) staff who will help drive change from within.
- If there are no internal change champions yet, who are some external champions to support change? E.g., expert panel.

3. Technology

Explore technology readiness and/or suitability for facilitating virtual provider services.

- Evaluate the existing technology infrastructure, i.e., hardware, software, network capabilities and bandwidth to support existing technology and/or upgrades.

- Evaluate the capacity of relevant teams, i.e., Digital Health, Information Technology, etc. to house new technology to support virtual physicians in a home-grown manner vs. via a third-party vendor.
- Explore data security and privacy requirements and compliance. Specifically, each health authority must conduct their own privacy and security process:
    - completed PIA's can be requested directly between privacy departments for review and templating
    - health authority may complete their own SSA (Security Self Assessment) or STRA (Security Threat and Risk Assessment) as they see fit.
- Identify existing processes in place to leverage for virtual care (e.g., RUDI).
- Assess availability and compatibility of telehealth platforms, electronic health record systems, and communication tools required to facilitate integration and coordination between virtual and on-site care providers.

4. On-site clinical staff

Explore the capability of the site to accommodate hybrid model of care approaches.

- On-site physician available for hands-on care if required in critical situations, either providing care alongside virtual physician, resting on-site, or on-call in the community.
- If no in-person physician available, alternative staff with competency in complex clinical interventions typically performed by physician if relevant including airway management, central line insertion. This may include NPs, RNs with rural certification (if adequate for site) or other relevant additional training, Respiratory Therapist (RT), Advanced Care Paramedics.
    - Scope optimization for profession within site or region in place to reflect alternative care.
    - Robust transfer process and risk management strategy for such situations.

5. Funding

Explore financial feasibility of implementing a hybrid model of care.

- Create a detailed report on the current mitigation strategies (e.g., locums, recruitment, etc.) and associated costs being used at the site/within the health authority to mitigate service disruptions (e.g., diversions, staffing incentives, etc.).
- Identify available funding sources at the site/within the health authority that could potentially be used for this project.

Appendix B: HMOC education framework

Domain	Key Topics
Organizational & Operational	• Orientation: Introduction to HMOC • Organizational Orientation • Community Resources • Documentation • Billing
Clinical Practice	• Patient Assignment & Triage • Assessment • Escalation Processes • Clinical Procedures • Patient Safety

Domain	Key Topics
	• Communication Skills • Pt/family Centered Care; Patient Support and Experience
Regulatory, Ethical, Legal	• Regulatory Bodies • Scope of Practice • Privacy and Confidentiality • Informed Consent
Technology & Digital Literacy	• Tech Proficiency • IT Support • Data Security and Privacy • Digital Communication • Data Sovereignty • System Access • Downtime Procedures • Navigating Technology Failures
Interprofessional Collaboration	• Team Function & Coordination • Roles & Responsibilities • Referral Processes • Care Coordination • Team Huddles & Team Communication Practices
Communication & Continuous Learning	• Ongoing Education • Quality and Feedback • Enabling Patient Engagement and Access • Patient and Family Centered Care
Indigenous Responsibilities	• Cultural Safety Standards • Legislation • Wise Practice Approach • Evaluation & Engagement Framework for Indigenous Patients & Communities
Accessibility & Equity	• Patient Safety • Tech Needs (language, interpretation, setup)

Appendix C: Change Management Template Example: Pilot Site #1

Application of ADKAR Change Management Model for Hybrid Model of Care Implementation at Pilot Site #1			
Stage	Objective	Completed Activities	Upcoming Activities (as of July 2024)
Awareness (of the need for change)	**Ensure that employees understand the need for change.**	✓ Partner engagement ✓ Informational interviews ✓ Patient/Provider interviews/video ✓ Informal socialization ✓ Executive and senior leadership awareness/endorsement	• Ensure clear and consistent messaging • Develop a comprehensive comms plan outlining the reason for change (e.g., emails, newsletters, town halls)
Desire (to participate and support the change)	**Encourage employees to support and participate in the change.**	✓ Engagement Sessions ✓ Pre-virtual kick off survey ✓ Virtual kick off ✓ In person innovation day	• Change Champions: Identify change champion(s) to advocate for change at Pilot Site #1 • Incentives and Rewards: Develop a recognition program to reward early adopters and those who actively support the change; Create incentives aligned with the change objectives • Feedback Mechanisms: Establish channel(s) for employees to provide feedback/ask questions
Knowledge (on how to change)	**Ensure employees have the knowledge and skills to support the change.**	✓ Whiteboards (COMMS board) ✓ Survey boxes on the floor ✓ Memo, staff newsletter ✓ Engagement with local partners (change champions) ✓ In person engagement with staff ✓ Point person on site	Training • Develop and deliver training tailored to different roles • Provide training using a variety of methods Knowledge Sharing • Pre-pilot kick off to share what to expect leading up to the pilot launch • Create a knowledge repository with resources, FAQs, best practices Vendor • Create role-specific guides (with step-by-step instructions) Support • Provide a channel to provide real-time support
Ability (to implement required skills and behaviors)	**Ensure employees can implement the change effectively.**		• Conduct skill assessments to identify gaps and areas needing improvement. • Develop targeted training to address these gaps. • Pilot Programs: Implement pilot program to test the change on a small scale • Use feedback from the pilot to refine processes and training before full implementation

Application of ADKAR Change Management Model for Hybrid Model of Care Implementation at Pilot Site #1			
Stage	Objective	Completed Activities	Upcoming Activities (as of July 2024)
			• Coaching and Mentoring: Encourage managers to offer continuous support and guidance • Performance Monitoring: Establish metrics and KPIs to monitor performance and progress
Reinforcement (to sustain the change)	**Ensure changes are sustained and expected results are delivered over time.**		*To be considered.*

Appendix D: SBAR communication template (adapted for virtual care)

Section	Description	Notes for Virtual Use
Situation	Briefly state the current situation or issue	Use clear, concise language; confirm the recipient is ready to listen (e.g., via chat/video)
Background	Provide context or relevant history	Share electronic health record (EHR) links or documents as needed
Assessment	Share your clinical assessment or observations	Use data from virtual assessments (e.g., patient-reported symptoms, video observations)
Recommendation	State what you need or suggest as the next step	Confirm agreement and clarify responsibilities for follow-up virtually

Example:

- **Situation:** "I'm contacting you about Mr. Lee, who has reported increased shortness of breath during his virtual visit today."
- **Background:** "His COPD diagnosis was confirmed last year; he was stable until last month."
- **Assessment:** "Based on his reported symptoms and oxygen saturation readings from his home monitor, I'm concerned about possible exacerbation."
- **Recommendation:** "I recommend we arrange an urgent virtual assessment with the respiratory specialist and review his medication plan."

Appendix E: Virtual care huddle template HMOC teams

Agenda Item	Purpose	Lead/Facilitator
Welcome and Introductions	Brief team check-in and attendance	Team Lead
Patient Updates	Share critical patient information and recent changes	MRP
Roles and Responsibilities	Clarify tasks and responsibilities for virtual care delivery Clarify who the in community back up physician is for each site.	Team Lead
Technology and Connectivity	Discuss any technical issues affecting virtual care Confirm communication of virtual physician to site	Tech Support Lead
Cultural Safety Considerations	Highlight any cultural or language needs impacting care	Cultural Liaison
Patient and Family Engagement	Plan strategies for improving virtual patient/family involvement	Care Coordinator
Wrap-up and Next Steps	Summarize action items and schedule follow-up huddle	Team Lead

Appendix F: Provincial Evaluation framework

Health Quality BC Dimensions of Quality	Quintuple Aim
Safety	Safe and Effective Care The care patients receive is safe and effective.
Respect	
Effectiveness	
Appropriateness	
Accessibility	Access Closer to Home Provides access to hospital care closer to where patients live
Equity	
Efficiency	Health Provider Experience Improves healthcare provider experience
	Health System Efficiency Improves health equity and efficiency in the healthcare system

Evaluation Domain	Key Evaluation Questions	Sample Metrics
Service Continuity & Access	Are service interruptions being reduced through virtual coverage? Is access closer to home maintained?	• # of virtual physician shifts • # of virtual physician hours • # of service interruptions prevented • Transfers avoided • Number and name of sites/services • Clinical service areas # of patients seen • Average patient load per shift # of patient encounters • # of service interruptions prevented
Patient Safety	Is virtual care safe? Are adverse outcomes minimized?	• In-hospital mortality within 7 days • Readmission within 72 hrs • Escalation events/use of protocols • Transfers back to ED from inpatient units • Time to physician assessment
Clinical Effectiveness & Appropriateness	Is the care appropriate, timely, and clinically effective?	• Patient discharge vs. admission diagnosis • EQ-5D scores • Preventable deterioration • Length of stay • PREM scores (physician & virtual care domains)
Patient Experience	Do patients feel informed, safe, and supported?	• Patient consent rates • Virtual care PREM feedback • Open-ended comments

Evaluation Domain	Key Evaluation Questions	Sample Metrics
		• Access to interpreters • Patient experience surveys
Provider Experience	Are providers (virtual and onsite) supported and engaged?	• Staff experience surveys • Sick calls • Recruitment trends • Provider documentation quality
Equity & Indigenous Anti-racism protocol	Is care equitable and culturally safe, especially for Indigenous populations?	• Indigenous access rate • Interpreter use • Training completed (ISAR, cultural safety) • Feedback from Indigenous patients • Barriers (tech, trust, trauma)
System Efficiency & Cost	Does the model support system sustainability and cost-effectiveness?	• Patient load per shift • Cost of virtual physician contract • Avoided diversions • Bed capacity/utilization • Cost of service interruptions • # of calls to community in-person physician • # of calls to on-call diagnostics
Implementation & Scalability	Is the model functioning smoothly, and is it scalable?	• Technology issues • Pilot successes/challenges • Expansion readiness • Entry/exit criteria adherence
Contextual Factors	How does site context affect outcomes?	• Site characteristics • Availability of onsite MRP • Service model in use
Unintended consequences	What is the proportion of physician time is for virtual shifts vs. In person shifts?	• Physician time and location

CRITICAL: ensure patient registration for virtual physician care is coded separately from onsite physician care from the beginning of the pilot. This is critical to differentiate and pull data from automated processes and reduce manual data pulls.

Appendix G: Sample Pilot Support Plan

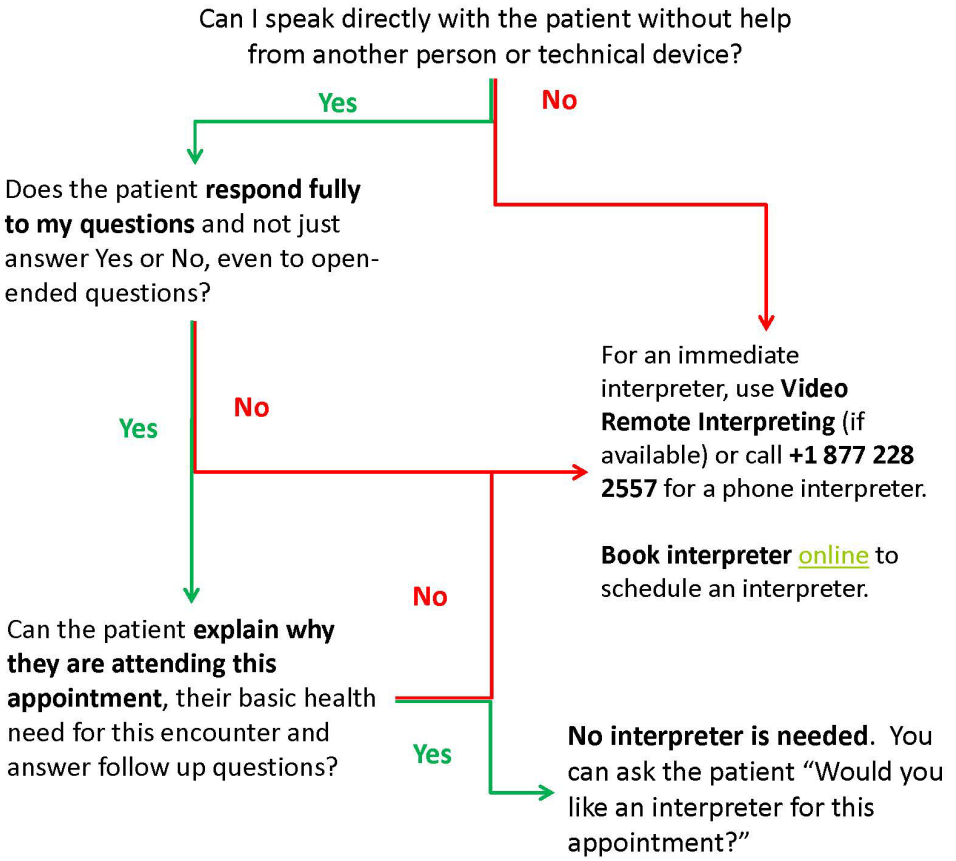
Example Support Plan from Pilot Site #1:

Launch	Stabilization	Sustainment/ Optimization
First week	**2 to 4 weeks**	**Ongoing**
Daily *Virtual leadership escalation call: Go over issues and resolve issues real time*	•***Weekly*** *Virtual leadership escalation call*	•***Monthly*** *Virtual leadership escalation call*
Command Centre via teams chat for centralized support virtually	• Command Centre via teams chat for centralized support virtually	
Clinical and operational at-the-elbow support (from in-person leadership, e.g., clinical leaders, etc.): *Identify site level champions for extra training*	*NA*	*NA*
Digital Health at-the-elbow support	*NA*	*NA*
Issues Log	*Ongoing*	*Ongoing*
On-site escalation pathway	*Ongoing*	*Ongoing*
Digital Health Support pathway for on-site staff and virtual physicians	*Ongoing*	*Ongoing*
---	---	New staff onboarding/orientation support *Provide overview of workflow and processes to agency nurses temporarily on site*

Appendix H: Accessing Provincial Language Services

Do I need to access an interpreter?

Evidence shows that health care providers cannot accurately assess the language comprehension abilities of patients. This tool helps assess your patients' and/or their support peoples' **English health** literacy and identifies potential language barriers that may negatively affect health outcomes and the quality of care.
Note: **Pronunciation and accents vary** from countries and regions. Accents should not be a factor in assessing a patient's English health literacy.



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