

Provincial Hybrid Model of Care: Virtual MRP Guideline

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Territorial Acknowledgement

Provincial Virtual Health acknowledges that hybrid care services are delivered across the homelands of diverse First Nations, Inuit, and Métis peoples throughout what is now called British Columbia. We recognize the deep, enduring relationships that Indigenous Peoples maintain with their lands, waters, languages, and cultures, and we honour their stewardship since time immemorial.

This Guideline is intended for provincial use and therefore reflects a pan provincial acknowledgement. Health authorities and sites are expected to adapt and extend this acknowledgement to honour and recognize the specific Host Nations on whose lands their services operate, and to engage Indigenous partners in alignment with Health Standards Organization (HSO) 75000 Cultural Safety and Humility Standard and wise practice approaches.

Executive Summary

The Problem

Persistent shortages of Most Responsible Providers in rural and remote BC hospitals create service interruptions, reduce Emergency Department, Inpatient Unit, and Urgent Primary Care capacity, and increase pressure on local teams. The Hybrid Model of Care (HMOC) integrates virtual Most Responsible Provider (MRP)s with on-site teams to preserve services when in-person provider coverage is unavailable. In-person care will always be the standard; HMOC: Virtual MRP is positioned as a complementary service interruption mitigation tool alongside recruitment, retention, incentives, and locum programs.

Target Settings

Small to mid-size hospitals and urgent primary care services in rural and remote communities where in-person MRP coverage is unstable or at risk of interruption.

Who This Guideline Serves and How

For Executives (VPs, CMOs, EDs): Clarifies the case for HMOC: Virtual MRP, service model options, governance expectations, Indigenous and equity obligations, and conditions for safe success and outlines necessary supports to fund: virtual team formation, enabling technology, readiness, education, and evaluation aligned to provincial reporting.

For Clinical Providers (MRPs, NPs, Nursing, Allied Health): Defines where HMOC: Virtual MRP fits to complement existing clinical workflows and minimum standards to integrate this model of care into an onsite team.

For Operational Leaders (Site Directors, Managers, PCCs): Provides high-level overview of readiness factors, workflow mapping expectations, technology and privacy steps, and site considerations for implementation.

For Project, Digital Health, Privacy, Evaluation, and Support Teams: Offers the minimum requirements for the HMOC: Virtual MRP services, including virtual care platforms, access to clinical systems, downtime procedures, interpretation integration, PIA and STRA completion, and evaluation alignment. The HMOC: Virtual MRP Implementation Playbook contains the detailed templates and tools.

For Patients, Families, and Communities: Recognizes patients, families, and communities as central partners and intended beneficiaries of HMOC: Virtual MRP. Their needs, experiences, preferences, and local context should inform the design, implementation, and evaluation of the model through meaningful engagement, feedback, and co-design.

How to use this document:

This Provincial Virtual Health HMOC: Virtual MRP Guideline outlines the principles, minimum expectations, and province aligned standards for safe, consistent hybrid care. It is aligned with existing and emerging policy direction and is intended to support consistent minimum standards across B.C., while allowing for regional and local adaptation. Use it to determine when HMOC: Virtual MRP is appropriate, choose a service model, and confirm readiness across sites, teams, technology, equity, privacy, and security. Apply it to set boundaries, escalation pathways, and evaluation expectations across Emergency, Inpatient, and Urgent Primary Care. Adapt it to your local context, including governance, site needs, and regional policies. For implementation steps, templates, tools, workflows, and training aids, refer to the HMOC: Virtual MRP Implementation Playbook. The Guideline reflects expert review and will continue to evolve as policy, practice, and evidence develop.

How this Guideline relates to the HMOC: Virtual MRP Implementation Playbook:

The Guideline defines the purpose, policy boundaries, and minimum provincial standards for Hybrid Models of Care - why HMOC: Virtual MRP is used, when it is appropriate, and the conditions required for safe, equitable, effective delivery across B.C. It establishes a consistent provincial foundation while enabling regional contexts and care environments to shape local application.

The Playbook provides the operational how-to for planning, building, launching, and sustaining hybrid care, including tools, templates, workflows, training resources, evaluation steps, and case examples.

Use the Guideline to confirm appropriateness, readiness, standards, governance expectations, Indigenous and equity obligations, and evaluation requirements.

Disclaimer and Limitation of Liability

The guidance and implementation strategies outlined in this Hybrid Model of Care Guideline highlight evidence-informed best practices and recommendations for use in healthcare settings. This guideline has been written by provincial subject matter experts and uses the best available knowledge and resources at the time of publication. The guidance provided is for informational and guidance purposes only and do not constitute legal, clinical, or regulatory requirements. While every effort has been made to ensure accuracy and relevance, the authors and publishers disclaim any liability for errors, omissions, or outcomes resulting from the use of this material.

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It is the responsibility of each healthcare provider or organization to ensure compliance with applicable laws, regulations, and professional standards in their jurisdiction.

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1. Purpose

This Hybrid Model of Care (HMOC): Virtual MRP Guideline provides guidance for regional health authorities exploring and/or implementing HMOC: Virtual MRP, where virtual Most Responsible Providers (MRP's), physicians or nurse practitioners, work alongside on-site teams to deliver integrated care. The purpose of this guideline is to support the integration of virtual care into health care settings to reduce unnecessary and avoidable service interruptions (i.e. emergency department closures, inpatient unit diversions and/or acute care bed reductions, primary care access challenges).

In-person care is the standard for healthcare delivery in all healthcare settings; however, ongoing health human resource challenges highlight the need for standardized hybrid care to support continuity of services and prevent disruptions. Hybrid care is a complementary tool alongside existing mitigation strategies, such as recruitment and retention efforts, incentives, and locum programs. It offers a structured approach to purposefully integrate virtual and in-person clinical services.

HMOC: Virtual MRP enables equitable access, clinical consistency, and long-term sustainability, and aligns with provincial healthcare priorities to enhance workforce resilience, optimize workforce utilization, and enable high-quality care for all communities. HMOC: Virtual MRP services are designed to follow a wise practice approach that upholds the province's commitments to align with HSO 75000 Cultural Safety Standards intended to work towards the eradication of Indigenous-specific racism from healthcare settings for First Nations, Métis, and Indigenous Peoples living in urban, rural and remote communities.

The guideline draws on key best practice sources, including the Virtual Care Clinical Reference Group Final Report (2023), the Canadian Association of Emergency Physicians (CAEP) Position Statement on Virtual Care in Emergency Medicine (2025), College of Physicians and Surgeons of BC on Virtual Care (2023), and lessons learned from HMOC: Virtual MRP initiatives across British Columbia (BC). These efforts are informed by research and partnerships with experienced teams across Canada. As CAEP (2025) highlights, virtual emergency care should be driven by current evidence on patient outcomes, clinical performance, operational efficiency and best practices. Guidelines should be regularly updated, supported by standardized data across the system to enable real-time monitoring, inform policy, and improve hybrid care delivery. Within the guideline there is a commitment, a legal obligation, to the eradication of Indigenous – specific racism within healthcare settings that is paramount to best practice standards. The guideline draws on key best practice sources - the Indigenous Cultural Safety and Humility Standard (HSO 75000), BC Accessibility Act, Anti-racism Data Act, BC Indigenous Language Legislation, Ownership, Control, Access and Possession (OCAP) and other related legal obligations.

This guideline aims to set clear boundaries for HMOC: Virtual MRP use, embedding a quality framework to support patient safety and clinical operational excellence through consistent, province aligned implementation.

2. Scope

This guideline applies to the integration of a virtual provider as the Most Responsible Provider (MRP) within an in-person care team. It is intended for hospitals and health centres across B.C., with a particular focus on rural and remote settings. The guideline supports emergency and inpatient care services in small to mid-sized hospitals, as well as health authority urgent primary care services. Virtual care delivered in large or

urban centres is out of scope of this guideline, as are home-based virtual care and peer-to-peer virtual consultations. Health authorities are expected to adapt the development and implementation of hybrid care models to meet the needs of their patient populations and clinical services.

3. Strategic Oversight and Partnerships

British Columbia Ministry of Health (MoH): Sets strategic direction, policy oversight, and funding priorities.

Provincial HMOC: Virtual MRP Advisory Committee: This provincial governance group has representation from the Ministry of Health, all health authorities and key partner organizations including Rural Coordination Center of BC, Doctors of BC, and the University of British Columbia. The group provides guidance on model development, supports alignment across health authorities, and recommends standardized approaches to ensure consistency, quality, and equity in care delivery across the province. It serves as a collaborative forum for sharing insights, addressing challenges, and advising on policy and operational decisions related to the HMOC: Virtual MRP.

Regional Health Authorities (HAs): Accountable for planning, implementation, funding, evaluation, and operationalization of services within geographical region, regional contracts, and site-specific integration.

Provincial Health Services Authority (PHSA) Provincial Virtual Health (PVH): Supports provincial coordination and collaboration across regional health authorities to develop provincial standards and supports consistency in service model development, implementation and monitoring.

Patient Advisory Committee: Provides a patient-centered perspective to strategic planning and service design. This committee ensures that patient voices and lived experiences inform policy, service design, and quality improvement initiatives.

4. Defining Virtual and Hybrid Care

Virtual Care is defined as any interaction between patients and/or members of their circle of care with their care team, occurring remotely, using any form of communication information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care (Canadian Institute for Health Information (CIHI), 2025).

Hybrid Models of Care (HMOC): Virtual MRP combines both virtual and in-person healthcare services to provide a flexible, integrated, and patient-centered approach to care delivery. For the purpose of this guideline, Hybrid Models of Care incorporate a virtual provider (Physician or Nurse Practitioner) into clinical service design and in-person care teams to manage patient care on-site in hospitals and health centers. Using remote technology, the virtual provider supports all aspects of care delivery - including assessment, diagnosis, referrals, treatment, discharge. Escalation options are in place for rapid in-person assessment, when required. This guideline does not replace or restrict existing peer-to-peer virtual consultations (e.g., specialist advice or collegial consults), which remain part of standard clinical practice. Hybrid Models of Care specifically refer to care models in which a virtual physician or nurse practitioner assumes the role of Most Responsible Provider in collaboration with an onsite care team.

5. Guiding Principles

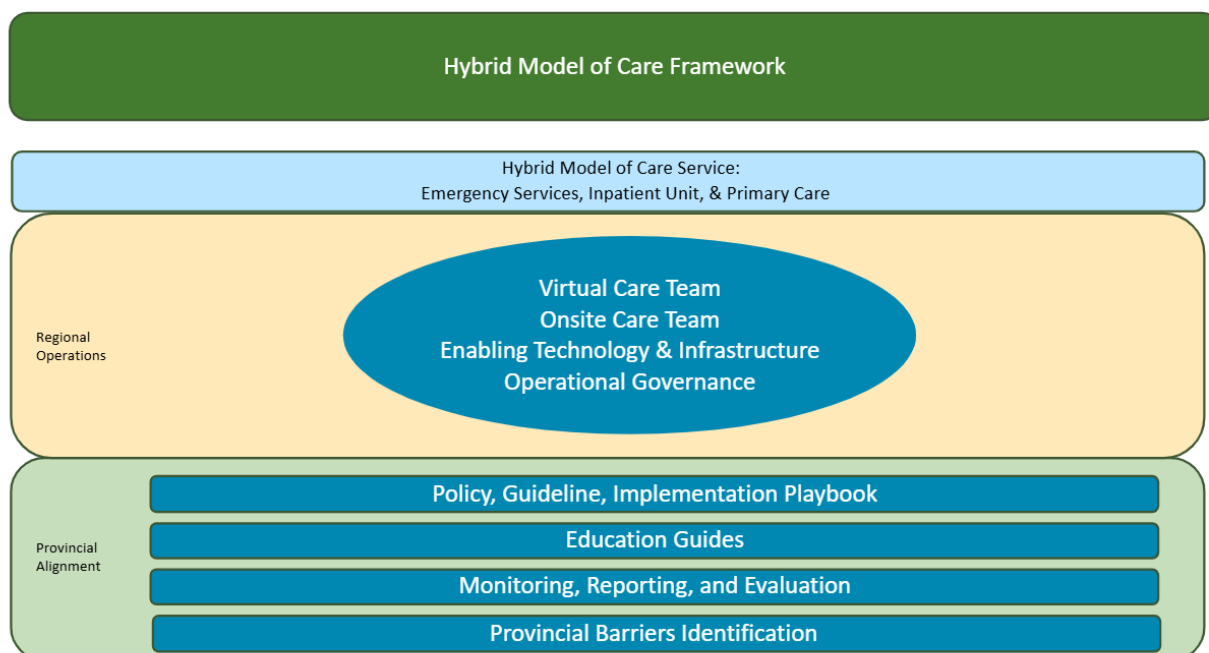
Hybrid Models of Care adopt a principles-based approach to the design, implementation, and integration of equitable, high-quality care. The core principles guiding hybrid models of care are consistent with the British Columbia Health Quality Matrix (BCPSQC, 2020) and recommendations of the Virtual Care Clinical Reference Group (VCCRG) and CAEP Position Statement on Optimizing the Role of Virtual Care in Emergency Medicine (2025).

- **Quality and Safety:** Ensure virtual care is delivered safely with appropriate clinical oversight and follow-up mechanisms. The same quality assurance processes that apply to in-person hospital care should also be applied to virtual providers to maintain quality standards.
- **Integration:** Virtual care is intended to complement and enable in-person care, not replace it: virtual care should be integrated into in-person services and workflows should be co-designed with in-person clinical staff.
- **Effectiveness:** Virtual care should be evidence-based and continuously evaluated for effectiveness, efficiency, and impact.
- **Accessibility & Equity:** Virtual care should enhance patient access without creating additional barriers, this includes but is not limited to addressing digital literacy, infrastructure gaps, and language access, to ensure fair access to hybrid care services.
- **Person-Centred Care & Relationship Building:** Engage providers, care teams, system experts patients, and community leaders in planning and implementing virtual care and promote trust and communication.
- **Efficiency and sustainability:** Optimize financial, human, and technological resources for sustainable healthcare delivery utilizing data driven insights. Ensure virtual services and funding strengthens long-term system capacity and preserves care in community in a fiscally responsible way, without compromising necessary resources from in-person services.
- **Appropriateness:** Virtual care should be based on clinical appropriateness, patient needs, and the context of service delivery. Service design and care planning should define patient conditions and contexts that are best suited for virtual emergency, inpatient, and urgent care consultations to ensure virtual services are used only when safe, effective, and suitable. Transitions/escalations to in-person care must remain available.
- **Supportive of Indigenous Health:** Indigenous Specific Anti-Racism (ISAR) modality is central to ensuring that safety and accessibility of hybrid models of care are attained by Host Nations as well as First Nations, Métis and Urban & Away Indigenous Peoples. It is incumbent on all health authorities to embed the Indigenous Cultural Safety and Humility Standard (HSO 75000), BC Accessibility Act, Anti-racism Data Act, BC Indigenous Language Legislation, Ownership, Control, Access and Possession (OCAP) Standards, and other legal obligations across the engagement and evaluation frameworks.
- **Patient, Family, and Community Engagement:** Meaningfully engage patients, families, and communities as partners throughout the design, implementation, and evaluation of HMOC: Virtual MRP. Consistent with PHSA's Patient and Family Engagement Framework, engagement should be grounded in partnership, responsiveness, support, mutual respect, and equity, with diverse voices and lived experiences informing how care is designed and delivered.

6. Framework and Service Models

Provincial Hybrid Model of Care Framework

The Provincial Hybrid Model of Care Framework provides a flexible structure for delivering consistent, high-quality hybrid care across BC, while allowing communities to adapt models to local realities and patient needs. It balances regional flexibility with provincial consistency, strengthening system-wide resilience and sustainability.



***Informed by MoH Mandate Letter*

The Hybrid Model of Care Framework distributes responsibilities between Regional and Provincial levels to ensure consistent standards while enabling local adaptation.

Regional responsibilities:

- Virtual team operations (virtual MRPs and virtual operations team)
- Onsite care team roles, workflows, and escalation
- Technology deployment, device configuration, connectivity
- Local governance, staffing, and service-model selection
- Evaluation and reporting
- Education and training
- Ongoing operational support

Provincial responsibilities:

- Policy, standards, and minimum requirements
- Education frameworks, evaluation standards, and reporting

- Indigenous-specific anti-racism alignment
- Provincial planning for scalability, consistency, and resource prioritization

These components must work together to maintain safe, high-quality, and culturally safe hybrid care across B.C.

Hybrid Model of Care Service Components

The Hybrid Model of Care is structured around four foundational and integrated concepts that ensure safe, effective, and locally adaptable care delivery, which are managed at the regional level, and underpinned by provincially aligned policy & standards. These elements must work cohesively to create a disciplined and resilient hybrid care system that can meet diverse community needs while maintaining provincial consistency in standards and outcomes:

1. **Virtual Team – Clinical & Operations:** Virtual MRPs (physician or nurse practitioner) deliver remote clinical care in partnership with the on-site team. These direct patient interactions may be supported by a virtual operations team (remote nursing and clerical support) to ensure virtual patient assessment and treatment orders are transferred and actioned by the in-person care team according to the care plan. The size and staffing complement of the virtual operations team depends on site selection, volumes, and information systems available.
2. **Enabling Technology & Infrastructure:** Secure, reliable technology platforms that support the full integration of virtual and in-person care, including video conferencing, electronic health record (EHR) access (site dependent, but is highly recommended), remote diagnostic tools (e.g., e-stethoscopes), structured communication tools for clinical handovers, and contingency systems for managing technology failures or system outages.
3. **On-site Care Team Optimization:** Workflow mapping, role clarification, escalation pathways, and service redesign to support seamless collaboration between on-site and virtual providers.
4. **Operational Governance:** Clearly defined local, regional, and provincial structures that oversee strategic, logistical, and quality assurance functions, ensuring accountability, standardization, and continuous evaluation across all hybrid care models.

Locally and regionally, this is described across two domains: operational and clinical/medical

- Operational governance focuses on how the service functions day-to-day, including workflow design, staffing coordination, operational communications, and decisions related to pausing or adjusting virtual care processes for safety or capacity reasons.
- Clinical/medical governance focuses on clinical accountability and quality oversight, including how clinical decisions are supported, how quality and safety are monitored, and how escalation and transfer decisions are reviewed.
- Decision rights are often clarified at site and regional levels, including who has authority to adjust workflows, activate escalation pathways, or pause virtual ED coverage when safety thresholds are reached.

Service Model Development

Local and regional service model development should be informed by engagement with local MRPs (physicians and nurse practitioners), interdisciplinary care teams, digital and virtual care system experts, and

patients/community members, alongside a thorough needs analysis of local data, patient needs, and clinical service requirements within the community. Typically, these service models assume one virtual MRP is working at one site in a shift, except in cases which are discussed in the maximizing MRP capacity section.

As a project team, at minimum, the following data needs to be considered:

- Facility information: # of beds & healthcare service required (ED, inpatient, or primary care)
- Site visit volumes & peak times (daytime, evening, overnight)
- Current staffing model (daytime, overnight)
- On-site staff skills & certifications
- Primary driver of HMOC: Virtual MRP/problem to be solved (e.g. MRP shortage, infrastructure, staff burnout, long waitlists etc.)
- Number of upcoming service interruptions
- Number of service interruptions in the past 6-12 months
- Current short term mitigation strategy
- Patient and staff experience
- Understanding of Host Nations cultural protocol as well as the cultural needs of Métis, Urban and Away Indigenous Peoples on Host Nation land.

Depending on the problem to be solved and the scope of practice of the local care team, the following service models can be considered:

Service Model	Description	Driver/Problem to be Solved	Example Data Indicators	Escalation
Hybrid On-Site	Virtual MRP is working alongside an in-person MRP and an in-person care team. This model is intended to support workload by dividing MRP responsibilities between providers based on acuity and MRP capacity.	• Long waitlists • Patients leaving without being seen • Service interruptions due to MRP shortages or reduced capacity of existing on-site MRP	• ED wait times • % of patients waiting beyond target wait times • LWBS rate • Time to MRP assessment • # service interruptions • Patient and provider satisfaction	On-site MRP
Hybrid On-Call	Virtual MRP works alongside an in-person care team, with escalation to in person assessment/intervention from an onsite or community resting MRP, as needed.	• Service interruptions due to MRP shortage • Proactive overnight coverage • Allow limited community MRPs to rest	• MRP FTE availability vs. service demand • # of shifts unfilled • ED closure hours/Inpatient unit diversions/UPCC appointment reductions	Resting in-person MRP

Service Model	Description	Driver/Problem to be Solved	Example Data Indicators	Escalation
			- Provider burnout rates - Patient and provider satisfaction	
Fully Virtual	A virtual MRP is the sole MRP delivering care alongside an in-person care team, with escalations to hands on MRP care at another hospital with in-person MRP coverage. This model requires the capability to provide immediate stabilization and resuscitation for any time-critical emergency (life, limb, or organ-threatening), including airway, breathing, and circulatory support (via nursing rural/remote cert, advanced care paramedic, respiratory therapist and/or ambulance bypass, etc.), while arranging rapid transport/escalation to in-person MRP care	- Service interruptions due to MRP shortage - Proactive overnight coverage (alignment with Corridors of Care)	- MRP FTE availability vs. service demand # of shifts unfilled - ED closure hours/ Inpatient unit diversions/UPCC appointment reductions - Provider burnout rates or satisfaction - Patient and provider satisfaction	Resuscitation function (e.g. airway protection) provided by non-MRP, as per description

Note: Clear communication of available services should be provided to the public. Refer to CAEP statement for recommendations on how to communicate the designation of emergency departments that operate with virtual MRP support only (Kernick et al., 2025).

7. Use and Optimization of HMOC: Virtual MRP

Health authorities are recommended to engage with MOH and PVH teams for implementation support and resources. Planning and implementation details are supported by the ***HMOC: Virtual MRP Implementation Playbook***

Site Readiness for HMOC: Virtual MRP Integration

When designing virtual care and hybrid care service models, it is essential to determine if the site is ready to integrate this model of care.

Key factors include:

- **Site Readiness:** The site has been engaged to co-create their HMOC: Virtual MRP workflows, and have support, funding, and active participation from physician and operational leadership.
- **Virtual Team Readiness:** Virtual provider pool has been assembled and/or hired, and determination of what virtual supports are needed has been established & resourced appropriately. Virtual team has access and training to all related health authority systems.
- **Onsite Team Readiness:** Onsite team have appropriate resourcing (staffing), skill mix, competency, and training to deliver care in this hybrid environment.
- **Equity and Accessibility Considerations:** Tools used to enable HMOC: Virtual MRP are designed with respect and integrate features to ensure accessibility (e.g., screen readers, captioning, multilingual support) and inclusion of diverse cultures and beliefs.

8. Minimum Standards for Hybrid Model of Care (HMOC): Virtual MRP

This section outlines recommended minimum standards that support safe, high-quality, culturally safe, and coordinated hybrid care. The statements in this section are articulated as baseline conditions for initiating or sustaining HMOC: Virtual MRP. Operational detail, workflows, tools, and examples that support these standards are in the ***HMOC: Virtual MRP Implementation Playbook***.

The following minimum standards establish recommended conditions for safe, high-quality, culturally safe, and coordinated hybrid care. These standards define what must be true for HMOC: Virtual MRP to be implemented or sustained. The Implementation Playbook provides detailed guidance, tools, workflows, templates, and examples supporting each standard.

Clinical and Operational Safety Standards

HMOC: Virtual MRP services should:

- Maintain in-person care as the standard, with HMOC: Virtual MRP used to prevent or mitigate service interruptions.
- Include clearly documented escalation pathways, including response time expectations, accessible to all team members.

- Ensure decision rights are often clarified at site and regional levels, including who has authority to adjust workflows, activate escalation pathways, or pause virtual ED coverage when safety thresholds are reached.
- Structured start-of-shift huddles are used to confirm and operationalize pre-defined roles, workload allocation, and safety thresholds established during implementation. Huddles support shared situational awareness and daily adjustments, rather than initial service design.
- Use site-endorsed patient assignment criteria that match onsite capacity, acuity, and available technology. Clinical judgement must always be supported.
- Ensure competency for immediate stabilization and resuscitation for time critical emergencies, appropriate to the selected HMOC: Virtual MRP service model.

Technology, Connectivity & Clinical Information Standards

Sites should ensure:

- High-quality, reliable video and audio devices with appropriate peripherals. All tech must have tested backup modalities, supported by a documented and practiced downtime protocol that defines clinical workflows, escalation, and accountability during technology interruptions. Virtual MRPs have role-appropriate, pre-provisioned access to EMR/CPOE/DI/Labs and provincial systems (i.e. CareConnect, PharmaNet, etc.).
- Where EMR access is unavailable, standardized workflows for faxing/transcribing orders, results acknowledgement, and shift end follow-up are documented and assigned.

Privacy, Security & Legal Standards

- A Privacy Impact Assessment (PIA) and Security Threat and Risk Assessment (STRA) must be completed for the HMOC: Virtual MRP technology stack prior to clinical use.
- Virtual MRPs must obtain and document informed consent for virtual care, including limitations, risks, privacy considerations, and escalation routes.
- All documentation must meet the same legal and professional standards as in-person care and be integrated into the permanent patient record.

Indigenous Specific Anti-Racism, Equity & Accessibility Standards

HMOC planning, delivery, and evaluation must uphold HSO 75000 Cultural Safety and Humility Standard, BC Accessibility Act, Antiracism Data Act, OCAP®, and distinctions based Indigenous engagement. Racism Data Act, OCAP®, and distinctions based Indigenous engagement.

- All workflows must integrate 24/7 interpretation access and plan for low digital literacy, hearing/visual disabilities, and mobility/access needs.
- Sites must maintain cultural safety incident pathways, including Indigenous patient navigation and mechanisms for reporting, responding to, and learning from concerns.
- Implementation and service delivery must adhere to applicable Indigenous-specific Anti-Racism and Discrimination Policy set by the organization, in addition to applicable provincial and national guidelines. In addition, addressing the equity must include:
 - Respecting self-determination of Indigenous data sovereignty to promote equity. The achievement of this self-determination is defined by the right to govern, collect, access, use, and apply data about their communities rather than relying solely on non-Indigenous institutions to define needs and priorities

- Ensure representation and engagement for Indigenous people/groups (e.g. difference in on & off-reserve difference in health outcome is significant)
- Reinforce cultural safety in virtual care as discrimination and mistrust is recognized as a problem within in-person care. The same implication would apply virtual/hybrid care if this is not taken into consideration in design

Workforce, Credentialling & Governance Standards

- Each HMOC site must have a Site Operational Lead and Site Clinical Lead with explicit authority to adapt workflows and pause HMOC for safety.
- Virtual MRPs must be licensed, credentialled, and privileged at each site before providing care. Where additional virtual clinical roles (e.g., virtual coordination, flow, or clinical support roles) are involved in care delivery, appropriate authorization, onboarding, and governance mechanisms are established in alignment with local scope, role, and accountability requirements.
- Health Authority Medical Affairs must validate contracting, compensation, and scopes of practice for virtual MRPs.
- From a system perspective, repeated site-based credentialling and privileging can create administrative burden for physicians and local medical leadership. Aligning approaches where possible supports sustainability and facilitates cross-site virtual coverage while maintaining local oversight.
 - Technical privacy and records management must adhere to guidelines set by applicable organizational, provincial, and national policies. Organizational policies encompassing health records confidentiality, access, and consent
 - Organizational policies pertaining to health data retention and audit
 - Foundational pillars of policy required for privacy & security, data standards & integration, and technology are required to ensure interoperability in the shift to virtual services

Monitoring, Evaluation & Quality Standards

Sites should:

- Evaluate the HMOC: Virtual MRP service, in alignment with their organizational data and analytics team. It is recommended to align with the Provincial HMOC: Virtual MRP Evaluation Framework and report the minimum dataset (access, quality, safety, equity, PREMs/PROMs, provider experience).
- Participate in scheduled provincial reporting and reviews when requested.
- Define pause/stop criteria and incorporate them into local governance and escalation pathways.
- Evaluation and implementation guidance is located in the ***HMOC: Virtual MRP Implementation Playbook***.

Education and Training

Education and training plans apply to all participants in the care pathway, including virtual providers, onsite teams, and patients and their families/caregivers. Patients require education to engage effectively in virtual care, and personnel require training to support and interact with patients throughout the journey. For patients, a level of readiness to understand what hybrid care is and ability to provide informed consent on this new service model is essential. For staff, a level of readiness to implement services and collaborate virtually is required, but also to support the patient through their hybrid care experience with confidence.

Education Minimum Requirements

All HMOC: Virtual MRP sites must ensure that virtual MRPs, onsite teams, and patients/families receive training covering:

- Hybrid care orientation (purpose, role clarity, safety expectations)
- Clinical assessment and escalation workflows
- Technology operation and troubleshooting
- Privacy, informed consent, and documentation standards
- Indigenous cultural safety, anti-racism, and accessibility
- Interprofessional communication and teamwork.

Learning domains are highlighted above, and content is located in the **HMOC: Virtual MRP Implementation Playbook** to be used as a guide to create health authority specific education materials.

*Including patient partners in health authority/site specific education creation and training for all audiences is considered a best practice standard.

9. Rural and Remote Considerations

Rural Service Area (RSA) Level A sites are defined as small hospital sites in communities with less than 7 physicians (BC Government, 2025). Hybrid model of care for these sites is often required to enable care to remain within the community and reduce hospital transfers to larger communities and has been implemented in various forms for many years. These sites have unique challenges and further considerations when looking to introduce this model.

Operations & Service Delivery: Virtual MRP's may come from regional pools; however, this may not be sufficient to meet the needs and may need to come from a provincial service provider. Training, recruitment, scheduling, and performance management should be in line with provincial and regional standards. An experienced virtual operations team should support the delivery of virtual MRP services.

Understanding the context: Virtual MRP's need to understand the local context, including the community, hospital or health center and cultural context. They need to understand the available resources, expanded roles of clinicians, transfer considerations specific to the location and community expectations to ensure they provide safe, effective, and culturally respectful care

Technology & Information Systems: RSA Level A sites are typically paper based sites without access to the regional Electronic Medical Record (EMR) system. Any virtual MRP should have access to an EMR (and it is strongly recommended that documentation is forwarded to region) to ensure privacy standards are maintained, while utilizing site-based fax to transfer information. If computerized provider order entry is available (CPOE), this recommended.

10. Contract Management

Contracts for virtual health services and technology solutions should aim for provincial consistency and, wherever possible, be centralized to maximize economies of scale.

Key considerations for contracts:

- Standardized Agreements: Consistent contract templates across health authorities
- Provider rates & compensation structures (e.g. hourly, per-service)
- Service expectations: Availability, deployment of resources based on contract holder needs and priorities, response times, uptime guarantees
- Technology integration requirements: Compatibility with existing systems and EMRs
- Scope & Service Expectations: Clearly define deliverables, responsibilities, and performance metrics for virtual care providers and technology vendors.
- Performance Monitoring & Reporting: Require regular data sharing, reporting, and evaluation to assess service utilization and patient outcomes.
- Risk & Issue Management: Include mechanisms for dispute resolution, contract amendments, and contingency planning to address service disruptions or technology failures.
- Scalability & Sustainability: Allow for contract flexibility to support the expansion of HMOC: Virtual MRP services across different hospital sizes, urban, rural, and remote settings.
- Privacy: Compliance with FIPPA for patient information

11. Glossary

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

Acronym/Term	Definition
BCPSQC	BC Patient Safety & Quality Council
CAEP	the Canadian Association of Emergency Physicians
CIHI	Canadian Institute for Health Information
DI	Digital Imaging
ED	Emergency Department
EHR	Electronic health record
EMR	Electronic Medical Record
HMOC	Hybrid Model of Care
HSO	Health Standards Organization
ISAR	Indigenous Specific Anti-Racism
MOH	Ministry of Health
MRP	Most Responsible Provider
OCAP	Ownership, Control, Access and Possession
PHSA	Provincial Health Services Authority
PVH	Provincial Virtual Health
RSA	Rural Service Agreement

Acronym/Term	Definition
STRA	Security Threat and Risk Assessment
VCCRG	Virtual Care Clinical Reference Group

12. References/Related Materials

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