

Hybrid Model of Care: Virtual MRP Implementation Playbook

Prepared By: Provincial Virtual Health (PVH)

Prepared For: British Columbia Health Authorities

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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.

Executive Summary

The Problem

Persistent MRP (physician or nurse practitioner) shortages in rural/remote BC hospitals are causing service interruptions, reduced Emergency Department/Inpatient Unit/ Urgent Primary Care capacity, and burden on onsite care teams. Traditional mitigation strategies (locums, incentives, etc.) are not enough. HMOC: Virtual MRP integrates virtual MRPs into onsite care teams to prevent service interruptions while preserving in-person care as the priority.

Target Settings

Small–mid-size hospitals, particularly Emergency Departments, Inpatient Units, Urgent Primary Care Centres in rural/remote areas with unstable MRP coverage.

Who This Playbook Serves & How

For Executives (VPs, CMOs, EDs)

- In-depth explanation of the case for HMOC: Virtual MRP, service model decisions, risks, and success conditions.
- Provides a roadmap for implementation, funding, and outlines executive support.

For Clinical Providers (Physicians, Nurse Practitioners, Nursing, Allied Health)

- Clarifies roles, safety protocols, workflows, escalation, and tools to support hybrid teams function day-to-day.

For Operational Leaders (Site Directors, Managers, PCCs)

- Offers staged implementation steps, site visit checklists, training requirements, and readiness tools.

For Project, Digital Health, Privacy, Evaluation & Support Teams

- Provides templates, workflow mapping guidance, tech requirements, PIA/STRA supports, and evaluation frameworks for a soft launch and ongoing monitoring.

How to use this playbook:

Offered by Provincial Virtual Health at the Provincial Health Services Authority (PHSA), the HMOC: Virtual MRP Implementation Playbook translates the Provincial Hybrid Model of Care Virtual MRP Guideline into the practical implementation steps. Use this playbook to support the planning, development, launch, and sustainment of hybrid care across Emergency, Inpatient, and/or Urgent Primary Care settings, drawing on checklists, workflows, training resources, escalation protocols, evaluation tools, and other implementation supports.

The playbook is intended to be adapted to local context, including governance structures, site and community needs, and regional policies and processes. For principles and minimum expectations, refer to the Provincial Hybrid Model of Care: Virtual MRP Guideline.

The legend below helps you find supporting materials throughout the playbook. This playbook reflects multidisciplinary review and lessons from early sites, and it will continue to evolve as practice matures.

Legend:

 Template	Provincial resource template A standard template or tool provided for teams to download and complete.
 Completed Resource	Completed resource A fully completed version of the resource to illustrate expected use and formatting.
 Illustrative Case Example (Site Specific Experience)	Illustrative Case Example (Site Specific Experience) A brief scenario demonstrating how the resource or process is applied in practice.
 Checklist	Checklist A structured list of key actions or requirements to guide implementation and support consistent completion of essential steps.
 HMOC: Virtual MRP Guideline	HMOC: Virtual MRP Guideline The Guideline defines the purpose, policy boundaries, and minimum provincial standards for Hybrid Models of Care
 Rural & Remote	Rural and Remote Spotlight A focused example highlighting considerations, adaptations, or lessons learned when applying the resource in rural or remote settings.
 Indigenous Collaboration	Indigenous Collaboration An example or guidance illustrating how Indigenous perspectives, partnerships, or ways of knowing are meaningfully incorporated into the resource or process.
 Accessibility & Communication Needs	Accessibility & Communication Needs Checkpoint A brief prompt or checklist to ensure equity, accessibility, and inclusion considerations are reviewed and addressed throughout the resource or process.

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Disclaimer and Limitation of Liability

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Users of this implementation playbook agree to hold harmless the authors, contributors, and affiliated organizations from claims, damages, or liabilities arising from the implementation or interpretation of the hybrid care model, except in cases of gross negligence or willful misconduct.

It is the responsibility of each healthcare organization and Most Responsible Provider (MRP) to ensure compliance with applicable laws, regulations, organizational policies, and professional standards within their jurisdiction. Consultation with appropriate legal, clinical, regulatory, and organizational experts is recommended before adopting or adapting any component of this implementation playbook.

Contextual Note: Illustrative Case Examples (Site Specific Experience)

The examples, operational observations, workflows, staffing approaches, technologies, and evaluation methods presented in this playbook are drawn from specific implementation experiences and are provided for illustrative purposes only. They should not be interpreted as provincial standards, recommended staffing models or ratios, workload or performance benchmarks, governance requirements, or endorsed operating procedures, clinical standards or standards of care.

Organizations should determine appropriate operational models and implementation approaches based on local context, governance structures, patient populations and care needs, available resources, organizational policies and requirements, and applicable professional and regulatory standards.

Contextual Note: Technology Examples - The Technology examples are provided for illustrative purposes and do not constitute endorsement or procurement guidance.

Contact Info and Acknowledgements

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- First Nations Health Authority (FNHA), British Columbia
- Rural Coordination Centre of British Columbia (RCCbc)
- University of British Columbia (UBC)
- British Columbia Ministry of Health
- Provincial Virtual Health Patient Advisory Group, including patient partners/advisors from across Canada
- Doctors of BC, Clinical Advisory Group
- Digital Health Canada
- Alberta Health Services
- Saskatchewan Health Authority
- Ontario Health Services
- Nova Scotia Health
- Newfoundland and Labrador Health Services
- Health Prince Edward Island (PEI)
- Horizon Health New Brunswick

Developed by Provincial Virtual Health (PVH) at the Provincial Health Services Authority (PHSA) in collaboration with professional and patient partner subject matter experts from across Canada, 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: Virtual MRP implementation, with links to supporting templates/documents.

Introduction

Background and Description

Rural and remote hospitals within the province of British Columbia are experiencing MRP coverage shortages leading to service disruptions in Emergency Departments (ED), Inpatient Units, and Urgent Primary Care Centres. Current mitigation strategies include (but not limited to) securing in-person physician locums for inpatient and Emergency Department coverage. However, these measures are not sufficient to reduce the risk of service interruptions.

The Ministry of Health (MOH), Emergency Care BC (ECBC), 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: Virtual MRP) to help address the critical challenge of Most Responsible MRP shortages and service disruptions across the province. Hybrid Model of Care (HMOC: Virtual MRP) involves integrating virtual MRPs into in-person care teams to collaboratively manage patient care in in-person care settings.

HMOC: Virtual MRP 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 MRP support into a hospital. This model of care is not meant to replace in-person care; in-person MRP coverage should always be prioritized whenever possible. However, virtual MRPs can serve as a valuable resource to bolster the on-site team's capacity and prevent service interruptions when an in-person MRP is unavailable. Proactive consideration of the Hybrid Model of Care as part of service and workforce planning can help organizations establish the necessary foundations before an urgent service need or physician coverage challenge arises. Virtual MRPs maintain access to all existing local and provincial resources. All existing on-site services are accessible to patients in hospital while being followed by a virtual MRP.

Organizations Considering or Implementing HMOC:

Organizations considering HMOC: Virtual MRP are encouraged to connect early with available provincial and national supports, including Provincial Virtual Health (PHSA), the Provincial HMOC Committee, and the National HMOC Community of Practice. These connections provide opportunities for implementation consultation, peer learning, mentorship, and the sharing of implementation experiences and lessons learned across sites and jurisdictions.

Hospitals across the country have implemented HMOC: Virtual MRP, successfully providing appropriate levels of care to their patients with the support of virtual MRPs.



Completed Resource: HMOC: Virtual MRP Jurisdictional Scan 2025 for examples of models of care within Canada and additional information on the components described.

HMOC: Virtual MRP 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, combined with guidance from The Provincial HMOC Advisory committee and colleagues implementing similar models across Canada, have

informed the development of a comprehensive provincial framework and supporting resources. This framework offers a replicable solution for other health authorities facing similar challenges.

Indigenous Recommendations for HMOC: Virtual MRP

Virtual care aims to minimize the impact of distance and maximize access to care; thus, the Hybrid Model of Care project has a primary focus on small to mid-sized, including rural and remote, care settings. 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. Ministry of Health and PHSA (including Emergency Care BC and Provincial Virtual Health) are guided by the HSO (Health Standards Organization) 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 includes key reports on Indigenous-specific racism, discrimination, and truth and reconciliation. The *In Plain Sight* Report (2020) is a foundational resource addressing discrimination in health care. Other essential documents include *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (2019) and the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015a). These do not include any existing Host Nation Memorandums of Understanding and are not an exhaustive list. Métis, Urban, and Away from Home Indigenous Peoples should also be included in all discussions and decision-making.

In this playbook, any reference to Indigenous patients includes Host Nations, status and non-status individuals, as well as Métis (chartered and unchartered) and Inuit People. Indigenous also refers to Indigenous patients from other territories outside what we call BC and who reside as guests on Host Nation territory.

Overview of the HMOC: Virtual MRP Implementation

The decision to implement HMOC: Virtual MRP for clinical operations is owned and operated by each regional health authority. At the same time, provincial consistency should exist across HMOC: Virtual MRP policy and standards, guidelines, education and training, reporting and evaluation. Please refer to the Provincial Hybrid Model of Care: Virtual MRP Guideline for more information.



Provincial Hybrid Model of Care: Virtual MRP Guideline

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.

Hybrid Model of Care – High Level Project Phases



Enablers/ Dependencies

- Leadership endorsement & participation
- Virtual MRP pool (compensation, privileging, credentialing, schedule)
- Technology readiness & connectivity
- Privacy & Security (PIA, STRA)
- System access: EMR, CareConnect, PharmaNet, HA network
- Funding
- Change management & site readiness

Section 1: Readiness and Preparation

Implementation Overview

Before forming a full project team, understanding the stages of implementation and which HMOC: Virtual MRP service model is appropriate to address the identified clinical challenges is critical. This step helps clarify the future-state vision and informs project planning.

Identify Site(s) for Potential HMOC: Virtual MRP Support

The intake and assessment process begins by identifying one or more hospital sites within your health authority that may benefit from virtual MRP 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.



Checklist: HMOC Virtual MRP Readiness Consideration Checklist

Key Decisions & Requirements Prior to Start

- **Executive leadership:** funding approval and commitment to prioritize the project implementation & remove roadblocks
- **Site location & problem that needs to be solved**
- **HMOC: Virtual MRP service model**
- **Physician/Nurse Practitioner staffing model:** Determine whether to use a vendor for virtual physicians or leverage internal physician pool.

- **Physician/Nurse Practitioner contract:** Do the existing physician contracts support the HMOC: Virtual MRP service model?
- **Physician/Nurse Practitioner leadership and clinical operations leadership endorsement and dedicated participation**
- **Technology:** Utilize vendor technology or internal systems with existing privacy and security clearance.
- **Dedicated project team support**

Stages of Implementation

Step 1 - Readiness & Preparation (*approx. 4–8 weeks*)

- Secure leadership approval & funding
- Engage and confirm site location, service and compensation model with physician/nurse practitioner leadership
- Determine need for vendor-based solution or if solution will be developed in-house
- Confirm physician and clinical operations leadership champions from the site. Validate in-person staffing, including existing scope of practice

Step 2 - Project Initiation & Engagement (*approx. 4–8 weeks*)

- Stand up project governance and working groups
- Document and get approval for project charter and plan
- Determine need for technology and device procurement
- Engage local providers, clinicians and partner sites
- Engage & assess availability of laboratory and medical imaging at site to support
- Engage & assess ability of BCEHS to support
- Engage community & Indigenous partners
- Develop internal/external communications plan

Step 3 - Project Planning (*approx. 8–12 weeks*)

- Service model development, including workflow documentation
- Build the HMOC: Virtual MRP virtual care team
- Negotiate physician/technology contracts and coverage
- Initiate credentialing and access; enabling technology, infrastructure, and system access
- Begin device logistics and PIA/STRA
- Technology testing/network configuration
- Confirm escalation pathways and ambulance bypass
- Prepare support materials (site, patient, virtual MRP)
- Confirm current state workflows and build future state workflows (clinical and technology).
- Evaluation planning

Step 4 - Implementation Preparation (*approx. 4-8 weeks*)

- Site visits for workflow validation
- Technology testing/network configuration
- Validate escalation protocols
- Identify and orient site champions

- Prepare site support materials for patients, in-person and virtual providers.

Step 5 - Pilot Launch

- Train onsite and virtual staff on hybrid workflows and technology
- Launch site support materials
- Provide go live support, including at-the-elbow support and remote support
- Daily escalation huddles and rapid troubleshooting
- Initiate community messaging, prior to go-live
- Activate HMOC: Virtual MRP service

Step 6 - Pilot Conclusion and Sustainment (approx. 6+ months)

- Operationalize service, including support and governance
- Continuous improvement activities
- Resource sustainability planning
- Performance metrics & reporting
- Evaluation
- Scalability planning

**** Please note:** timelines are variable and dependent on a number of factors including, but not limited to:

- Dedicated resourcing
- Support from enabling teams
- Ability to complete contracts/assessments etc.
- Availability of suitable technology and devices; procurement would add months to timelines

Service Model Exploration

The following service models can be explored, based on the problem to be solved:

Service Model	Description	Example Drivers/Problems to be Solved
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 based on acuity and capacity.	• Long waitlists • Patients leaving without being seen • Service interruptions due to MRP shortages or reduced capacity of existing on-site MRP • Bed reductions
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
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), while arranging rapid transport/escalation to in-person MRP care	• Service interruptions due to MRP shortage • Proactive overnight coverage



Completed Resource: HMOC: Virtual MRP Drivers by Service Area and Service Model



Illustrative Case Example – (Site Specific Experience):

In the early stages of planning Cariboo Memorial Hospital decided to utilize a hybrid on-site model for workload augmentation and to solve the problem of inpatient bed reductions due to 50% physician line vacancies. They soft launched the service and quickly the winter holiday period brought additional scheduling problems; their onsite physician line could not be filled for two weeks. The team quickly changed to a fully virtual model for those two weeks to prevent full-service interruptions (of note: onsite physician was available in the emergency department as a back up). These service interruptions were

mitigated via the fully virtual model as the team had practiced the virtual workflows and trust of working with a virtual MRP team member from the on-site hybrid model of care and had become more accepted. The predominant model of care for Cariboo Memorial Hospital is an on-site hybrid model; however, by supporting the site in the lower risk HMOC: Virtual MRP model of care, they were able to open the door for greater adoption and flexibility of virtual MRP use at the site. Of note: this pilot utilized a vendor for virtual physicians, technology, and devices.

Funding:

Budget considerations:

One-time (implementation)

- Project team time/backfill (PM, clinical ops, Digital Health/IMIT, privacy/security, change management, comms, evaluation)
- Clinical engagement (MRP/nursing champions; paid sessions/honoraria as applicable)
- Training build + delivery (materials, simulations, onboarding packs)
- Technology set-up (devices, peripherals where used, mounts/charging, connectivity testing, spares)
- PIA/STRA effort + remediation work (time + any required technical changes)
- Vendor contract (as needed)

Ongoing (operations)

- Virtual MRP coverage
- Virtual operations supports (if used) (coordinator/remote nurse/scheduling)
- Digital Health/IMIT support coverage + device lifecycle (repairs, replacements, licensing)
- Evaluation + CQI cadence (dashboards, surveys, reporting)
- Equity/access supports (interpretation integration/testing, accessibility aids, culturally safe engagement)

****Practical tip:** Add a “stabilization buffer” line for the first 2–4 weeks after go-live (extra “at the elbow” support capacity).

Rapid Implementation

An accelerated timeline for implementation, also known as “rapid implementation,” may be possible under the following circumstances:

- expanding the use of a familiar vendor across to new sites
- expanding the use of an internal model across new sites

Rapid implementation has an expediated timeline as the health authority is familiar and had success with hybrid model of care, the processes to enable virtual MRP support have been completed for other sites and need to be expanded. It is not recommended to approach new service creation with a rapid implementation timeline due to the time and effort required for project teams to set up and test HMOC: Virtual MRP for the first time.



Template: HMOC: Virtual MRP Readiness Assessment and Rapid Implementation Tool



Completed Resource: HMOC: Virtual MRP Readiness Assessment and Rapid Implementation Plan Example



Illustrative Case Example (Site Specific Experience): Implementation approaches may vary by site, health authority, and jurisdiction.

Based on the success of the Hybrid On-site HMOC: Virtual MRP at Cariboo Memorial Hospital to eliminate service interruptions, Interior Health decided to create a new workflow to expand their services to include small Emergency Departments in the region. Time from project implementation to launch for CMH was 8 months; however, due to Interior Health's familiarity with this project and socialization through the health authority about the success of CMH, their Emergency Department pilot was able to soft launch in just 3 months, utilizing a rapid implementation timeline including resources from this HMOC: Virtual MRP Implementation Playbook.

HMOC Implementation Decision Points

Implementation of HMOC: Virtual MRP involves a series of decision points across the implementation lifecycle rather than a single Go/No-Go decision. These decision points support teams in determining whether the model remains appropriate for the local context, identifying areas requiring further development or mitigation, and adapting the approach as implementation progresses.

Key decision points may include:

- **Model fit:** Is HMOC: Virtual MRP an appropriate approach to address the identified service need and local context?
- **Model selection:** What HMOC configuration best aligns with the clinical setting, patient population, onsite resources, and existing service model?
- **Readiness:** Are the necessary clinical, operational, workforce, technology, privacy, and governance considerations sufficiently addressed to proceed with implementation planning?
- **Workflow and escalation readiness:** Are roles, responsibilities, communication processes, clinical workflows, and escalation pathways clearly defined and understood by virtual and onsite teams?
- **Pre-launch readiness:** Is the site prepared to proceed with launch, or are additional mitigations, testing, training, or workflow refinements required?
- **Early implementation:** Based on patient, provider, operational, and safety feedback, should the model continue as planned, be adapted, or temporarily paused while identified issues are addressed?
- **Sustainment and spread:** Do implementation experience and evaluation findings support sustaining, modifying, expanding, or adapting the model for other settings?

Decision-making should be proportionate to the implementation context and supported by appropriate clinical, operational, and organizational governance. Not all considerations will apply in the same way across sites or service models. Where gaps are identified, teams may proceed with defined mitigation strategies where appropriate, pause implementation to address outstanding issues, or reconsider aspects of the proposed model.

Section 2: Project Initiation and Engagement

Project Governance

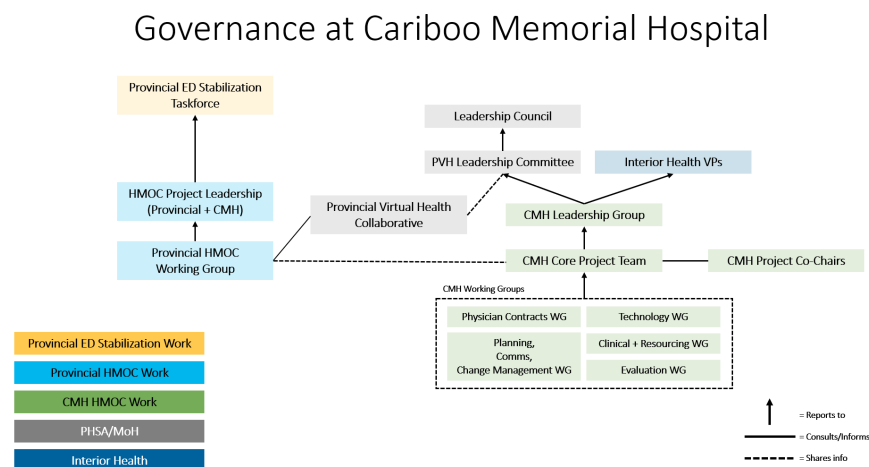
HMOC: Virtual MRP implementation typically involves multiple levels of change occurring in parallel and at different points of readiness, including individual practice change, department or team-level workflow change, site-level operational change, leadership decision-making change, and broader organizational change. Organizations should consider establishing an appropriate governance structure to support the planning and implementation of HMOC: Virtual MRP, aligned with their local context, existing governance mechanisms, and organizational requirements. Where appropriate, mechanisms may also be established to share implementation progress, lessons learned, and emerging practices with the Provincial HMOC: Virtual MRP Committee.

The following case example is provided to illustrate how one health authority structured governance to support HMOC: Virtual MRP implementation within a specific site and organizational context. It is intended as an illustrative example rather than a recommended or standardized governance model. Governance structures, roles, staffing and resourcing, decision-making authorities, and escalation pathways may vary by site, health authority, and jurisdiction.



Illustrative Case Example (site specific experience and should not be interpreted as provincial standard for governance structure):

HMOC: Virtual MRP Project Governance Structure at Cariboo Memorial Hospital (April 2024)





Rural & Remote Spotlight: Minimum viable project and operational governance in small sites:

Small sites often operate with high local independence and may make practical decisions locally based on immediate need. If local teams are not involved early, they may disengage or operate outside formal governance to keep patients safe.

Design implication: Treat local staff as co-creators of governance and not just implementers. Co-design “who decides what,” define hard stops, and ensure the governance structure is practical for limited bandwidth.

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) *
Sponsor	Chief and/or Vice President; Physician Leadership
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 • Clinical Care • Digital Health and Technology (Virtual Care, Devices, and Network) • Clinical and Medical Informatics • Health Information Management • Patient Flow • Privacy and Security • Evaluation & Reporting • Project Management • Change Management • Communications • Professional Practice • Physician Contracts/Medical Affairs • Indigenous Care • BCEHS (Ambulance Services) • Patient and Family Advisory
Local Context Lead (Onsite)	Site-based leader or designate with strong local knowledge

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

Working Groups and Deliverables

Once the site or regional health authority 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, Virtual Care, and Clinical Care) • Technology (Digital Health) • Evaluation • Resourcing/Training (HR, Education) • MRP Contracts • Change Management/Communications/Planning
Working Group Members (As necessary)	Subject Matter Experts from: • Clinical (Operations and Virtual Care) • Information Technology (Digital Health) • Clinical Informatics (Digital Health) • Professional Practice • Quality and Safety • Evaluation • Resourcing/Training (HR, Education) • MRP Contracts • Change Management • Communications • Indigenous Care • Physician/Nurse Practitioner Representatives • Patient Partner

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



Checklist: HMOC: Virtual MRP Site Implementation Checklist and Working Group Deliverables

provides a detailed list of implementation steps and deliverables for each working group

Project Staff Resourcing

This project is recommended to us a blended staffing approach that prioritizes existing capacity while ensuring the full project role complement is in place.

- Project Managers are dedicated to this initiative for the duration of implementation (while remaining within their broader portfolios) and are drawn from existing resources.
- Subject matter expertise (clinical operations and care, digital health/technology, privacy and security, evaluation, change management, communications, professional practice, physician contracts, Indigenous care, and patient/family advisory) will likewise be sourced from existing regional resources wherever possible.

- Where specific functions are not currently within the regional staffing complement, the region may decide to:
 - hire net new contract roles or secure temporary secondments/backfill
 - add capacity or targeted training to existing staff to hold the function within the project team, and/or
 - consult with the provincial team to complete both the team and project role complement.

Role assignments, FTE allocations, and backfill requirements will be confirmed with site/HA leadership at initiation and are the responsibility of the region to fund, unless otherwise negotiated with the province.



Rural and Remote Spotlight: Project staffing and relationship continuity

Trust is built between individuals, not departments. Frequent turnover in “urban project” contacts forces local teams to retell their story and leads to disengagement.

Design implication: Keep project team membership stable where possible, visit the site for context, and follow through on commitments consistently.

If/Then Adaptation: If roles must change, then execute a structured handover with the local team (introductions, documented decisions, open issues, and agreed next steps) to prevent trust erosion.

Change Management

To inform and support change management activities for HMOC: Virtual MRP implementation, teams may draw on established change management approaches that support structured, people-centred change in complex health system environments.

One commonly used approach is Prosci’s Awareness, Desire, Knowledge, Ability, Reinforcement (ADKAR) model (Prosci, 2026). ADKAR offers a practical lens for considering the human impacts of change and for identifying relevant engagement, communication, and readiness activities across different phases of implementation.

Teams may also reference other health-system-focused change management frameworks, such as Canada Health Infoway’s Framework and Toolkit for Managing eHealth Change (<https://www.infoway-inforoute.ca/en/component/edocman/resources/tools/4037-a-framework-and-toolkit-for-managing-ehealth-change>), which emphasizes engagement of clinical and operational teams, workflow integration, readiness assessment, and continuous feedback. This framework may be particularly helpful for sites seeking additional tools or perspectives to support digital health and virtual care adoption within local clinical and operational contexts.

In hybrid and virtual care models, change management is closely linked to how effectively teams are able to work together across distance. As Stephen Covey notes, “Change moves at the speed of trust.” In practice, trust influences communication, decision-making, and how readily teams adapt new workflows. Transitioning teams that typically work together in-person into virtual, or hybrid models introduces additional coordination and relationship challenges, particularly when teams are newly formed and have limited shared experience. In these situations, establishing clear working norms, role clarity, and reliable communication patterns becomes an important part of supporting change.

Sites may find it helpful to plan for relationship-building activities alongside technical and workflow implementation. Where feasible, this can include periodic in-person meetings for frontline teams, community partners, and leadership, supported through dedicated time and funding. These sessions can support early identification of concerns, discussion of workflow and safety impacts, shared learning, and relationship development that carries into virtual collaboration. When in-person connection is limited, similar outcomes can be supported through regular, structured touchpoints that create space for discussion, feedback, and problem-solving.

Rather than prescribing a single approach, the intent is to support sites in selecting and adapting change management methods that best align with their local context, scale, and capacity, while maintaining a consistent focus on staff engagement, safety, and sustainability throughout HMOC: Virtual MRP implementation.

What is unique about change management in HMOC: Virtual MRP?

Change management for HMOC: Virtual MRP extends beyond adoption of virtual technology. It involves changes to how clinical teams work together across physical locations, including redistribution of roles and tasks between virtual and onsite providers, new communication and escalation pathways, changes to clinical workflows and documentation, and increased reliance on onsite teams to facilitate aspects of virtual care. Implementation may also introduce new relationships between providers who have not previously worked together and may affect patient and family expectations of how care is delivered. Change management should therefore focus on building trust across distributed teams and in the technology that supports them, co-designing workflows, clarifying roles and accountabilities, monitoring workload impacts, and creating mechanisms for rapid feedback and adaptation.



Template: Change Management Workbook



Related resource: Canada Health Infoway – A Framework and Toolkit for Managing eHealth Change (<https://www.infoway-inforoute.ca/en/component/edocman/resources/tools/4037-a-framework-and-toolkit-for-managing-ehealth-change>)



Illustrative Case Example (Site Specific Experience): Change Management Model for HMOC: Virtual MRP at CMH



Illustrative Case Example (Site Specific Experience) Implementation approaches may vary by site, health authority, and jurisdiction. **Fraser Lake Diagnostic and Treatment Centre** is a small D&T centre in Fraser Lake, BC. They are a small team and were concerned about the safety and workload capabilities of their team to solve their service interruption problem using HMOC: Virtual MRP. A key step in their change management journey was to have their medical director and onsite ED physician be the champion of this project. This physician attended all meetings, brought positivity and curiosity about

how this new mitigation strategy could work for their healthcare centre, and was a champion for this work via actively participating with the onsite staff and co-creating the future state together.

Key Partner Engagement

Engaging key partners enables the project team to co-create the model of care, support awareness, alignment, and relationship-building 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 helps build shared understanding of the model of care which 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. Some examples of key partners include hospital leadership, emergency department teams, hospitalists, specialists, primary care providers, patient and family partners, Indigenous partners, and operational partners.

When to Engage

Engagement with key partners should begin as early as possible and continue throughout planning, implementation, and sustainment. Early engagement provides an opportunity to build awareness and understanding of HMOC: Virtual MRP before an urgent service need arises, establish relationships, identify local concerns and opportunities, and involve partners in shaping the model. Ongoing engagement supports continued alignment, feedback, learning, and adaptation as the model evolves.

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.

****Of note:** in-person engagements are important for relationship and trust building and should not be replaced with exclusively virtual engagement sessions. Virtual engagements may exclude important partners who are uncomfortable with technology and thus should be paired with opportunities to meet in-person.

Examples of engagement strategies include:

- Hosting a project kick-off
- Hosting a townhall for staff and/or the community
- 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

It is recommended to present HMOC proactively at existing medical staff, hospitalist, ED, site leadership, and regional operational meetings, including sites not yet implementing HMOC.

- Identify clinical and operational site champions who can enthusiastically share information, support peer-to-peer learning, answer questions, and bring feedback to the implementation team.
- Utilize multiple communication channels, tailored to local needs and stakeholder groups, and providing regular updates can help build awareness, address questions and concerns, reinforce key messages, and support alignment across clinical and operational teams.



Illustrative Case Example (Site Specific Experience): Engagement Activities at CMH



Illustrative Case Example (Site Specific Experience): HMOC: Virtual MRP CMH Virtual Project Kick Off Slide Deck



Illustrative Case Example (Site Specific Experience): HMOC: Virtual MRP CMH In-Person Engagement Planning Day Slide Deck

Who and How to Engage

Physicians and Nurse Practitioners	MRPs (physician and/or nurse practitioners) 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 MRPs is strongly recommended to ensure relevance, buy-in, and sustainability. Early engagement of community physicians will provide insights into downstream effects to health authority services and could help identify important clinical design elements at all stages of the patient journey (access, tirage, admission, discharge, follow up, etc.). Identify MRP site champions to participate in working groups and take ownership of clinical leadership throughout the development and implementation process. Ideally these people are respected and influential in the community. Their involvement helps guide decision-making, foster peer engagement, and support successful integration of the model into practice. MRP honorariums should be considered for virtual and in-person engagements.
Nursing	Nurses will be disproportionately impacted by HMOC: Virtual MRP and thus must be engaged thoroughly to address, monitor, and reduce the workload burden on them. Nurses must co-create workflows, training and simulations, and be engaged in regular feedback and PDSA cycles. Engagements should be within work hours, and/or compensated accordingly if after hours.
Other Clinical	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 MRPs, nursing, pharmacy, diagnostic imaging, laboratory, Emergency Medical Services (EMS), students, residents, rehabilitation, discharge planners etc. Engagements should be within work hours, and/or compensated accordingly if after hours.
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, clinical informatics, Professional Practice, Human Factors, Quality and Safety, administration, support staff including unit clerks etc., housekeeping, foodservices (depending on site context). Engagements should be within work hours, and/or compensated accordingly if after hours.
Patient Partner Engagement, including Indigenous Partner	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.

	- Consider the cultural diversity of the geographic areas and invite representatives from those groups to participate in patient partner engagement sessions. - 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. - Invite patient partners to team wide engagement events, as well as a representative on the core project team and working groups. - Expressions of appreciate can take various forms: honorariums, gifts, verbal/written acknowledgement during and after the engagement etc.
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Indigenous Collaboration: Partner Engagement Guidance

- Indigenous Nations with members who have previously/would likely visit the site and/or who live in the community are important partners to engage and should be imbedded into any patient partner engagement opportunities.
- Indigenous 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.
- The Health Director for the Health Unit for each local Indigenous community within the region is 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.
- 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).

** If engaging patient partners is new to your team, the Patient Voices Network has resources to support this. [Patient Voices Network: https://patientvoicesbc.ca/](https://patientvoicesbc.ca/)



Rural and Remote Spotlight (RSA): Managing resistance through trust

In tight-knit communities, acceptance can change quickly based on lived experience and peer-to-peer narratives. Resistance is best addressed through consistent presence, listening, engagement, and follow-through.

Design implication: Use relationship-based change management: show up, listen, respond quickly, and close the loop visibly. Co-create solutions and acknowledge constraints without defensiveness.

Minimum safe standard: Maintain reliable communication routines (touchpoints, escalation contacts, decision transparency) and act on concerns promptly.

If/Then Adaptation: If trust is declining (increased complaints, staff withdrawal, reduced uptake), then slow down, revisit co-creation, and resolve the root issue before scaling.

Communications

Communications for HMOC: Virtual MRP should help patients, families, providers, and partners understand how the model changes the way care is delivered, while reinforcing that virtual care remains part of the health authority's clinical service. Communications should clearly explain the role of the virtual MRP and onsite team, what patients and families can expect during a virtual encounter, how privacy and confidentiality are supported, how concerns or escalation are managed, and where questions or feedback can be directed. Messaging should be adapted as the model evolves and informed by feedback from patients, families, clinicians, and local partners.

Key aspects of the communications plan are as follows:

- Communications plan
- External news briefing
- Key messages
- Questions and Answers (Q&A)
- Patient public facing pamphlet and poster



Template: Communications templates

NOTE: If utilizing a vendor services, the services should be branded as a Health Authority service rather than using the vendor's name ("white labeling") This keeps all patient-facing materials vendor-neutral, so if the vendor changes, the health authority will not need to update public communications. The health authority is the service provider; the vendor works behind the scenes.

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 service model development team roles, technology infrastructure, workflows and more. Through collaborative engagement and planning, as described above, 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, coordinated, and efficient care delivery.

Service Model Development

Service Model Type	Core Characteristics (Planning Phase)	Illustrative Application
In-Person Hybrid	• Combination of virtual and in-person physician presence on-site	Emergency Department (ED)

Service Model Type	Core Characteristics (Planning Phase)	Illustrative Application
	- The in-person physician prioritizes hands-on assessment and treatment needs. - Clear division of responsibilities between virtual and in-person clinicians - Structured daily coordination (e.g., huddles)	- Virtual physician provides ED medical coverage - Registered nurses are on site - In-person physician is working alongside with workload division OR located in another clinical area of the hospital (e.g., primary care) and designated as back-up for escalation Inpatient Unit - Virtual physician represents a defined portion of the MRP complement (e.g., one of two FTEs) - In-person physician provides on-site coverage and escalation support - Workload divided each day through a structured morning huddle - Dedicated nurse assigned to support the virtual physician
On-Call Hybrid	- Virtual physician provides primary clinical coverage - Dedicated onsite nursing support during service hours - Physician coverage is supplemented by an on-call community physician for escalation - Often used for overnight coverage	Emergency Department (Overnight Coverage) - Virtual physician provides overnight ED medical coverage - Dedicated registered nurse is on site to support patient care and workflows - Community physician is on-call and available for escalation when in-person assessment or intervention is required

Service Model Type	Core Characteristics (Planning Phase)	Illustrative Application
		Escalation thresholds and expected response times are clearly defined-person assessment or intervention is required
Fully Virtual	- MRP services delivered entirely virtually - On-site nursing presence supports patient assessment and care delivery - Escalation 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	Urgent and Primary Care Centre (UPCC) - Virtual physician works directly with an onsite nurse - Scope limited to urgent and primary care presentations - Patients requiring higher acuity care are escalated via ambulance to the emergency department site nurse person physician required within the facility or as backup acuity care are escalated via ambulance to the emergency department

Risks and Benefits of HMOC: Virtual MRP Service Models

Service Model	Benefits	Risks
Hybrid On-Site	Maintains continuous in-person physician presence to support higher acuity and complex care. Enables distribution of MRP workload between virtual and in-person providers, improving patient flow and access. Supports continuity of care in ED and inpatient settings. Often more acceptable to care teams and communities during early adoption of virtual models. Can reduce wait times and improve responsiveness during peak demand.	- Requires sufficient onsite physician availability, which may be difficult to sustain in rural or remote settings. - Risk of role ambiguity if responsibilities are not clearly defined. - Increased operational complexity related to coordination and handoffs. - Virtual capacity may be underutilized if workflows default to in-person care.

Service Model	Benefits	Risks
Hybrid On-Call	- Provides service continuity when full onsite coverage is not feasible, particularly overnight. - Helps mitigate physician burnout by allowing limited community MRPs to rest. - Supports proactive coverage for known service gaps. - Preserves access to in-person assessment through defined escalation pathways. - More feasible in communities with limited physician availability.	- Reliance on resting or on-call MRPs may result in delayed in-person response. - Increased clinical risk if escalation thresholds or response times are not well defined. - Potential strain on a small pool of community physicians if on-call demand is frequent. - Requires strong nursing capability and confidence in escalation decision making with a virtual MRP.
Fully Virtual	- Maximizes limited MRP capacity and supports service continuity where in-person coverage is not sustainable. - Reduces service closures related to MRP shortages. - Enables efficient system level use of MRP resources across sites. - Well suited to urgent and primary care scopes with predictable acuity and clear escalation pathways. - May improve access and reduce patient travel in remote communities.	- Not appropriate without reliable immediate stabilization and resuscitation capability for high acuity care settings. - Higher reliance on nursing scope, training, and clinical confidence. - Increased risk in the presence of transport delays, weather disruptions, or technology failures.

Staffing Considerations

Vendor Considerations

Based on existing staffing capacity and expertise within the region and/or the availability and maturity of internal technology, a region may choose to engage a vendor for some or all components of the hybrid model of care. This is an important decision to contemplate in the early stages of the project.

When virtual provider services are delivered through a third-party vendor, service concerns must be addressed through a clearly defined governance structure. This structure should be reflected in service level expectations, contractual agreements, and privacy and security provisions established by the health organization as part of procurement.

A formal health authority–vendor review pathway should operate alongside existing mechanisms for incident management, clinical quality reviews, change requests, and information sharing. This pathway must clearly outline:

- what information can be shared and under what conditions,
- how review discussions are conducted,
- how decisions, approvals, and changes are made, and
- how outcomes are documented within existing organizational systems.

It is essential that organizations fully understand their internal processes and governance structures as they relate to the technology, services provided, and the implications for the HMOC: Virtual MRP model. This includes clarity on where HMOC: Virtual MRP decisions are made and which governance tables or committees must be engaged, based on the organization's current operating model and vendor agreements.

Pros of using a vendor include:

- rapid startup given prior implementations in other jurisdictions and readymade workflows/toolkits-up given prior implementations-made workflows/toolkits
- operational support and 24/7 coverage with defined service level agreements
- access to specialized expertise (virtual care operations, training, analytics, quality/safety)
- scalability during surges
- reduced burden on local teams for maintenance, upgrades, and user support
- proof of concept for a region
- ability to quickly implement while building internal capacity for virtual MRP and/or internal technology solutions for long term sustainability

Cons of using a vendor include:

- longer procurement/contracting timelines
- higher total cost of ownership (licensing, integration, change management, and transition fees)
- potential integration complexity with existing clinical systems
- vendor locking or limited customization-in or limited customization
- data governance/privacy considerations (e.g., residency, access, retention)
- the need to set clear parameters—including prohibiting vendors from hiring your own physicians and “renting” them back
- defining credentialing/privileging responsibilities
- specifying branding/white label expectations (service presented as the Health Authority's). -label expectations (service presented as the Health Authority's).

Regions should also plan for business continuity and exit (transition out support, data portability), ensure role clarity for incident management and clinical escalation, and confirm cultural fit with local practice standards and Indigenous and partner engagement. Where functions are not available internally, regions may hire net new contract roles, upskill existing staff, and/or consult with the provincial team to complete the project and operational role complement.

Maximizing MRP Capacity: Utilizing One MRP Across Multiple Sites

As part of service model development, regions may consider a multi-site MRP model to optimize physician capacity while maintaining safe, reliable patient care - particularly in low volume, rural, or remote settings.

In a multi-site MRP model:

- A single MRP provides virtual MRP support to multiple sites.
- This model is typically appropriate when individual site volumes are low, but aggregate demand across sites supports efficient use of physician capacity.
- This model is dependent on the sites having the same electronic medical record and a robust communication system to understand patient load and priorities across all sites.

Considerations for Implementing a Multi-Site MRP Model

To determine whether a multi-site MRP model is appropriate, regions should consider the following:

- **Site readiness:** Select sites that have demonstrated familiarity with a virtual MRP support model (e.g., one MRP supporting one site) prior to transitioning to a multi-site configuration.
- **Site remoteness:** Prioritize sites where service interruptions would require patients to travel greater than two hours to access care.
- **Site volumes:** Multisite MRP models are best suited to low volume sites, where full onsite physician coverage is not sustainable.
- **Aggregate volumes:** Assess the total patient demand across all participating sites to ensure workload remains manageable for a single MRP.
- **Triage alignment:** Establish a consistent triage framework across all sites to support equitable and clinically appropriate prioritization.
- **Patient sorting across sites:** Develop agreed-upon protocols to guide how patients are prioritized when multiple sites have patients with similar acuity levels.
- **Electronic health record:** A shared or interoperable electronic health record across all sites is strongly recommended to support timely access to patient information, continuity of care, and clinical decision-making.
- **In multi-site virtual ED coverage,** a coordination role has been valuable to support communication and flow across sites. This role typically acts as the key point of contact between sites, supporting huddles, escalation routing, and hand-off reliability. The role has most often been filled by an RN, though in some contexts an LPN or clinical administrator has fulfilled the function depending on scope and workflow.

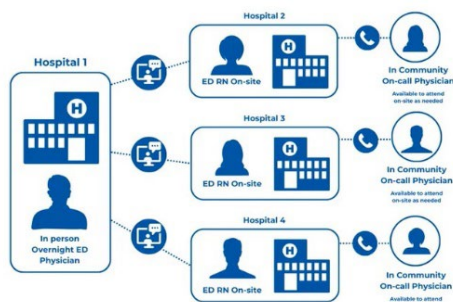


Illustrative Case Example (Site Specific Experience): Model Fit / Site Types (LINK-ED Example):

Implementation approaches may vary by site, health authority, and jurisdiction.

- LINK-ED was designed for low-volume, low-acuity rural Emergency Departments. Within the observed implementation context, virtual physician workload was approximately two patients per hour.
- **Contextual considerations:** The model was designed within the context of low-volume, low-acuity rural Emergency Departments. Applicability to higher-volume or higher-acuity/procedural environments, or sites without reliable staffing, escalation, and transfer processes, requires consideration of local context and organizational requirements.

IH Overnight Emergency Department Virtual Hybrid Model of Care



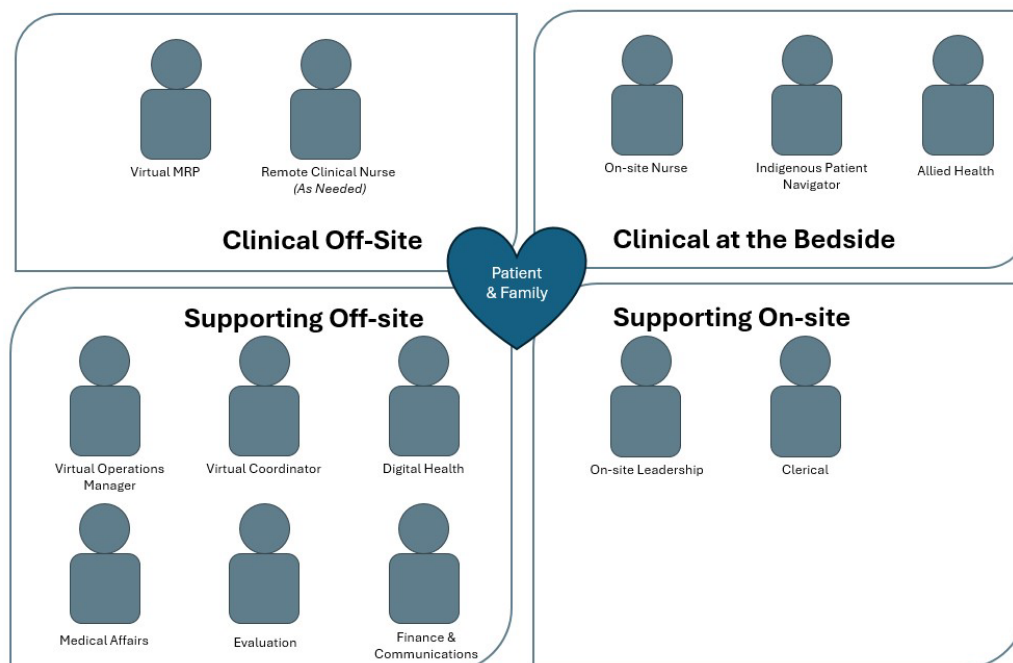
- One physician provides overnight on-site coverage at a primary hospital.
- The same physician delivers virtual MRP support to three additional hospitals, each with an average of approximately two patients per night.
- Daily or shift-based virtual huddles are conducted across all sites, followed by communication via shared collaboration tools (e.g., Teams chat).-based virtual huddles are conducted across all sites, followed by communication via shared collaboration tools (e.g., Teams chat).
- Nurses may contact the virtual MRP directly as clinical needs arise.
- Each community receiving virtual MRP support has a designated local back-up community physician for escalation if required

Nurses at all sites access a shared patient dashboard displaying all patients within the department (1), CTAS score (2), patient location, (4), the queue of patients awaiting virtual MRP support (4), chief complaint (5) and associated patient vitals and/or related patient care tasks (6), see below:

HMOC: Virtual MRP Service Delivery Components

Building the HMOC: Virtual MRP Team

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 MRP and patient for their care interaction; it is recommended to have the following staffing compliment:



ILLUSTRATIVE EXAMPLE: Bedside Staffing Approaches by Service Model at a Glance:

Based on lessons learned from our pilot sites in British Columbia, the following on-site staffing models have been considered.

Please note: these are only examples and are not prescriptive. The intention is to give insight into the staffing compliment that has been successful in our pilots.

	Emergency Department	Inpatient Unit	Urgent Primary Care
On-site Hybrid	Designated RN to Virtual MRP On-site physician for escalation	Designated RN to Virtual MRP On-site physician for escalation	Designated RN to Virtual MRP On-site physician for escalation
On-Call Hybrid	Designated RN to Virtual MRP In community physician for escalation	Designated RN to Virtual MRP In community physician for escalation	Designated RN to Virtual MRP Escalations to Emergency Department
Fully Virtual	Designated RN to Virtual MRP Escalations to other team member with resuscitation	Designated RN to Virtual MRP Escalations to Emergency Department OR other team	Designated RN to Virtual MRP

	Emergency Department	Inpatient Unit	Urgent Primary Care
	capabilities for stabilization and transfer	member with resuscitation capabilities	Escalations to Emergency Department

Virtual MRP Pool of Providers

Role of the Virtual MRP: The virtual MRP is assigned for a cohort of patients and could be a physician or nurse practitioner. They are 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. In BC, if the virtual MRP is employed by the site/health region, they report directly to medical leadership within the site/health region, and if employed via a vendor service, they report into the company/organization and site/health region medical leadership.

Virtual MRP Staffing Considerations

When developing an HMOC: Virtual MRP service, organizations should determine the most appropriate virtual provider model based on patient acuity, service scope, local workforce availability, and operational requirements. Staffing decisions should be made in collaboration with Medical Affairs, clinical leadership, and operational leaders.

Provider Model Options

Organizations may utilize:

- Physician-led virtual MRP model
- Nurse Practitioner-led virtual MRP model
- Blended Physician and NP model
- Internal health authority providers
- Third-party vendor providers
- A combination of internal and external resources

Key Planning Considerations

Selection of the provider model should consider:

- Clinical setting (ED, inpatient, UPCC)
- Patient acuity and complexity
- Escalation requirements
- Availability of onsite clinical resources
- Existing physician and NP workforce capacity
- Coverage requirements (single site or multi-site)
- Compensation and contractual arrangements
- Credentialling, privileging, and regulatory requirements

Minimum Requirements

All virtual providers must:

- Hold applicable professional registration and licensure.
- Be credentialled and privileged according to health authority requirements.
- Complete required orientation and training.
- Have clearly defined escalation pathways.

- Practise within their approved scope and local service model.

Credentialling and Privileging Considerations

Credentialling and privileging can create significant implementation workload, particularly where site-specific processes are required. Organizations should engage Medical Affairs early to clarify applicable requirements. These processes remain subject to local governance and regulatory requirements and are outside the direct control of the HMOC: Virtual MRP program. Greater provincial alignment, such as standardized privileging frameworks or a common privileging dictionary with local oversight, may help reduce administrative burden and support future scale and spread of HMOC.

Staffing Principle

There is no single recommended provider staffing model for HMOC: Virtual MRP. Staffing should be determined locally based on the service being supported, patient population, workforce availability, and organizational requirements.

Virtual operations team and support composition

The following roles are recommended for the virtual clinical support and operations team:

1 operational team could operate up to 5 sites with 1 additional nurse (nursing may increase depending on site volumes, virtual MRP needs, and presence (or lack of) of an electronic medical record). *Note: the roles and FTE described are based on lessons learned from current models underway across Canada and could be changed based on need/capacity. The FTE and roles stated below are for consideration and are not prescriptive.*

Role Type	FTE	Responsibility
Virtual Operations Team		
Director	0.25	Provides strategic oversight, ensures alignment with across the health authority, and secures executive support and resources. Recommended for support across multiple sites, this may be a part of a larger portfolio of virtual care and/or clinical operations.
Manager	1.0	Oversees day-to-day operations, coordinates across teams, and ensures timelines and deliverables are met. Recommended for support across multiple sites, this may be a part of a larger portfolio of virtual care and/or clinical operations.
Coordinator	1.0	Manages logistics, scheduling, communication between virtual clinical and operational teams to keep implementation on track. Recommended for support across multiple sites, this may be a part of a larger portfolio of virtual care and/or clinical operations.
Virtual clinical nurse	1.0	Supports virtual MRP and frontline teams day-to-day with information flow, ordering, and follow up; supports frontline team with training and quality assurance. This role is usually utilized if there is no or variable use of an electronic medical record and faxing information is required and/or there is a time delay on information transfer and order processing. If a site does have an electronic medical record, this role may not be needed.
HMOC: Virtual MRP Support Services		

Role Type	FTE	Responsibility
Medical Affairs	0.1	Reviews contracts, privacy, liability issues to ensure compliance with provincial and/or regional regulations and virtual care standards
Digital Health	1.0	Provides functional technical assistance for virtual care platforms, troubleshoots technology issues, contributes to staff training around use of technology. Manages Electronic Medical Record (EMR) integration, tech support, update and maintain technical and clinical workflows. <i>* Likely a composition of different skill sets and staff from digital health.</i>
Finance	0.1	Manages budgeting, cost tracking, and funding allocations to support sustainable implementation.
Communications	0.1	Develops internal and external messaging to support partner engagement, change management, and public awareness.
Evaluation	0.1	Develops, manages, and tracks all evaluation and quality improvement activities.
Other Admin	0.1	Provides essential administrative functions such as documentation, scheduling, and coordination across departments and sites.

On-Site Care Team

Role Type	FTE	Responsibility
On-Site Care Team		
Assigned Nurse or delegate	1.0	The on-site nurse or designated delegate (e.g., Licenced Practical Nurse (LPN), MRP's assistant) is assigned to facilitating the virtual MRP's connection with the patient. They are the primary liaison between the patient and the virtual MRP and explain the process to the patient prior to the interactions. The on-site nurse supports MRP assessment via providing physical assessment findings verbally and/or operating any necessary peripherals (e.g., stethoscope) to complete the MRP's assessment.
On-site or On-Call MRP	As needed	Provide care for patients who require hands-on assessment. On-site MRP is responsible to follow-up with the virtual MRP for any patient handover or shift changes.
On-site leadership	Existing FTE	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	Existing FTE	Support the care journey of the patient and family, require awareness to HMOC: Virtual MRP workflows.

Role Type	FTE	Responsibility
On-site Indigenous patient navigation	Existing FTE	Access to Indigenous patient navigators available to Indigenous patients onsite.
On-site administrative/clerical staff	Existing FTE	Support information transfer between the unit and the virtual MRP, and vice versa.



Illustrative Case Example (Site-Specific Experience): LINK-ED - Onsite Staffing and

Readiness

The following reflects experience within specific LINK-ED implementation contexts and is provided for illustrative purposes only. Onsite staffing and readiness considerations are commonly aligned to patient volume, acuity, and phase of implementation.

In the LINK-ED experience:

- During launch phases at low-volume sites, a minimum of one RN onsite per shift supported safe operation.
- In multi-site models, the hosting site benefited from additional staffing to coordinate across sites and act as the primary communication hub. This role was most often filled by an RN, though in some settings an LPN or clinical administrator fulfilled the function depending on scope and workflow.

Overall experience suggests that when onsite staffing levels align with model assumptions, implementation is more stable and effective.



Provincial Resource: HMOC: Virtual MRP Roles and Responsibilities Matrix



Rural and Remote Spotlight: Onsite Nursing support in single nurse sites

Some rural/remote sites operate with one nurse who covers triage, assessment, treatment, monitoring, and urgent response, especially on day shift. In these settings, “dedicated nursing capacity” may be ideal but is not always feasible. As part of supporting the virtual encounter, onsite nursing responsibilities may also include sharing relevant patient education and educational resources and obtaining or supporting applicable consent in accordance with organizational policies and procedures.

Design implication: Define the nursing support requirement as “safe and reliable nursing support matched to local capability,” rather than a blanket expectation of a dedicated nurse. Local capability includes nurse experience, scope, training, and comfort level with the site’s edge of care context.

Operational Consideration: It is recommendation that the nurse be able to pause/suspend virtual encounters immediately to respond to time critical events without compromising patient monitoring or staff safety.

If/Then Adaptation: If the local team indicates that current staffing/competency does not support safe virtual workflows, then do not force a standard model. Re-scope the service (scope, pace, patient selection, hours) through site specific co-creation.

Enabling Technology & Infrastructure

Technology Selection & Considerations

Technology is a foundational enabler of safe and effective Hybrid Models of Care. Virtual MRPs must be able to assess, monitor, document, and communicate with the same clinical confidence as in-person providers, while onsite teams must be supported with tools that reduce-not add to-workload.

Technology selection and configuration should therefore be driven by clinical requirements first, with operational and technical considerations aligned accordingly.

Core Technology Requirements

At a minimum, HMOC: Virtual MRP technology must support:

- High-quality, reliable video and audio quality, reliable video and audio
- Clear visualization of the patient, bedside team, and clinical environment, supported with clear audio at acceptable volumes
- Meet infection prevention, privacy, and security requirements

Strongly recommended functionality:

- Camera zoom functionality for focused assessment
- Noise reducing microphones suitable for clinical spaces
- Where funding is limited, prioritize camera quality and screen size for the virtual MRP over patient-facing displays

Clinical peripherals (strongly recommended)

- Electronic stethoscope, otoscope, and/or exam camera where clinically appropriate
- Use of peripherals remains at the discretion of the virtual MRP and dependent on local nursing capacity and comfort

Connectivity and resilience

- Have both wired network connectivity and Wi-Fi for connectivity
- Ability to transition seamlessly to backup modalities (secondary device or phone) in the event of failure
- VPN or alternative secure tunneling solutions for off-site clinicians
- Battery to support extended wireless use

Accessibility features required:

- Screen-reader compatibility
- Live captioning and audio controls
- Ability to add interpreters and support persons to visits on demand
- Compatibility with assistive and adaptive technologies

Usability and workflow fit

- Intuitive operation for bedside nurses, clinicians, and patients
- Minimal steps to initiate a consult
- Rapid login and reconnection capability for time sensitive scenarios

- Emphasis has been placed on technology that is user-friendly, low-barrier, and easy to use in urgent clinical workflows.
- Teams have noted that privacy and security requirements can introduce friction if solutions are overly complex. A balanced approach supports privacy and regulatory compliance while maintaining clinical usability and avoiding delays in care.

Privacy and security practices should be reinforced through staff training and periodically reviewed as services mature.

Security and Access Requirements

Systems supporting HMOC: Virtual MRP must maintain robust security consistent with clinical and privacy standards including organization requirements for:

- Domain authentication and identity management
- Single Sign-On (SSO) integration
- End-user device access controls
- Presentation layers appropriate to workflow (local apps, web-based, or hybrid models)
- Rapid login and reconnection capability to support urgent clinical scenarios



Rural and Remote Spotlight:

Technology in low-support environments: In rural/remote sites, high-end technology can become a barrier if training and support are inconsistent (e.g., staff turnover) or if the team is carrying multiple roles and cannot troubleshoot.

Design implication: Test connectivity using a realistic clinical simulation (mimic an actual patient visit with the full toolset) and select technology that is reliable and simple to use. “Open a ticket” is not sufficient as the primary support pathway. Real-time operational support is required.

Minimum safe standard: Define real-time support: a person/site-accessible escalation route that can be contacted during a live encounter.

If/Then Adaptation: If bandwidth or usability is uncertain, then build Plan B/C workflows (phone fallback, simplified peripherals, alternate device) and test them before go-live.

Technical support and escalation

- Clearly defined first line and second line support pathways
- Technology support includes:
 - Clear support pathways for frontline staff, starting with site-level troubleshooting and escalating to Digital Health/IT as needed
 - Enhanced support during early implementation phases (e.g. through huddles, job aids, and quick-reference materials)
 - On-call support during hours of HMOC: Virtual MRP operation, especially during launch and stabilization -call support during hours of HMOC: Virtual MRP operation, especially during launch and stabilization
 - Technical support must include a real-time contact pathway during active encounters, not only asynchronous ticketing.

- Ongoing optimization cycles to address recurring workflow issues and reduce administrative or cognitive burden



Resource: HMOC: Virtual MRP Device Clinical and Technical Requirements



Illustrative Case Example (Jurisdiction-Specific Experience): Technology Approaches used in BC in 2025

Location	Technology
Interior Health: Inpatient Northern Health: ED & UPCC	Mobile Virtual Care stand with attached tablet for hands free virtual consultation and peripheral examination devices. 

Interior Health: LINK-ED RCCBC: VERRa ED	Clinical tablet with smartphone backup for mobile virtual consultation (no peripheral examination devices)  Picture courtesy of Rural Coordination Centre of BC
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Downtime and Contingency Planning

All HMOC: Virtual MRP sites must have a documented, practiced downtime protocol, including:

- Increasing staff training & awareness for immediate fallback to alternate communication methods (e.g., phone) and established workflows
- Escalation to onsite or in-person coverage and/or transfer pathways if virtual connections cannot be restored within a defined timeframe
- Communication of downtime procedures through onboarding, huddles, posted unit references, and periodic refreshers or drills to maintain confidence and safety
- Clear accountability for clinical decision making during technology failure
- Workflows, processes and procedures to support patient care during the downtime and reconciliation of documentation and orders once systems are restored
- Defined “pause or suspend virtual care” criteria for safety critical situations
- Process-based support in the form of phone lines, embedded help tools
- Local support of developed system (with IT being the primary source of support along with superuser groups on site)
- Prioritization and tracking of incidents & ongoing issues requiring support
 - SBAR
 - Issue ticketing system and/or submission forms
 - Staff resources and support material for downtime workflow management
 - Priority scoring
 - Dedicated teams addressing various levels of support (i.e. patient care, device, workflow, etc.)
 - Escalation contacts/channels (including primary and secondary contacts when applicable)

System Access

Required System Access for Virtual MRPs

Virtual MRPs must have role-appropriate access to the same clinical applications and supporting technologies within the health authority and province required to safely discharge MRP responsibilities, including:

- Site Electronic Medical Record (EMR), where available
- Computerized Provider Order Entry (CPOE)
- Diagnostic imaging and laboratory results systems
- Provincial systems such as:
 - CareConnect
 - PharmaNet
 - Other regional or specialty EHRs used to support clinical decision making -making

Access must be:

- Provisioned before go-live
- Tested end-to-end during training and soft launch
- Aligned with privileging and scope of practice at each site

Security and Privacy

Hybrid care introduces additional privacy and security considerations that must be addressed proactively to maintain patient trust and legal compliance.

Privacy and Security Governance

Regional privacy and security teams must be engaged early to allow sufficient time for:

- Privacy Impact Assessment (PIA)
- Security Threat and Risk Assessment (STRA)

Legislative and Professional Standards

HMOC: Virtual MRP implementations must comply with all applicable legislation and standards, including:

- FOIPPA and/or PIPA, depending on organizational context
- E-Health Act and provincial disclosure directives
- CPSBC Virtual Care Practice Standard CPSBC-PS-Virtual-Care.pdf
- [CMPA guidance on consent, risk disclosure, and documentation](#)
- [Health Canada Virtual Care Policy Framework](#)
- [BC Ministry of Health – Information Management Regulation](#)
- [Federation of Medical Regulatory Authorities of Canada. FMRAC Framework on Virtual care](#)
- [Health Information and Interoperability Standards Catalogue](#)
- Existing standards & guidelines for face-to-face delivery of care including privacy, confidentiality, and consent

Managing Fragmented Information Environments

British Columbia's patient data environment is fragmented, particularly across rural and remote sites. Where shared EMRs or direct order entry are not yet available, regions must intentionally design compensatory workflows, which may include:

- Dedicated virtual coordinators or remote nurses to support order processing and follow-up -
- Secure, standardized processes for transmitting orders and results via fax or other mechanism
- Clearly defined accountability for:
 - Acknowledging results

- Acting on abnormal findings
- Ensuring follow-up after the virtual MRP's shift ends

Early identification of system gaps and explicit mitigation strategies is essential to avoid unsafe workarounds and increased nursing burden.

Electronic Medical Record and Documentation

Clear, timely documentation is critical to patient safety, continuity of care, and medico-legal accountability in hybrid models.

Documentation Principles

All virtual MRP documentation must:

- Meet the same clinical, legal, and professional standards as in-person care
- Be integrated into the patient's permanent health record
- Be visible and accessible to onsite care teams in real time or near real time site care teams in real time or near-real time

Virtual MRPs must document:

- Clinical assessment and decision making at the time of the clinical encounter including patient history, findings, assessment, plan of care and changes in condition or clinical management
- Care plans, orders, referrals, consults, and escalation decisions including medication documentation and/or medication reconciliation (as appropriate) especially at transitions of care
- Handover at shift change or transfer of responsibility
- Consent for virtual care, as applicable Methods used to provide care such as phone and/or videoconferencing
- Any accessibility needs and/or features utilized

EMR Use and Future Direction

Where an EMR exists:

- Virtual MRPs should document directly into the site EMR
- Duplication of documentation across systems should be avoided

Where EMR capability is limited or absent:

- Interim workflows must be formalized and standardized
- Clear ownership must be assigned for faxing, transcribing, and uploading documentation
- Risks related to delays, omissions, or version control must be actively monitored

Future Direction:

There is a recognized need for longer term development toward streamlined province-wide EMR access for virtual providers. While this remains an area of ongoing system development, HMOC: Virtual MRP implementations must plan within current constraints and design safe interim solutions.

Provincial Direction and Standardization

While regions may use different platforms, early standardization within and across health authorities is strongly recommended to support scalability, cross site coverage, and workforce mobility. -site coverage, and workforce mobility.

Key principles:

- Virtual MRPs should not require fundamentally different technology to move between sites or regions
- Technology choices should align with provincial virtual care standards and approved platforms wherever possible
- Vendor solutions must be configurable to meet health authority branding, workflow, and data governance expectations -authority branding, workflow, and data-governance expectations



Indigenous Collaboration: Indigenous Data Governance

- **Ownership & Control:** Follow OCAP®; seek community-level agreements for secondary use/reporting that may identify communities.
- **Access:** Role-based access; community view of aggregate findings; apply <5 cell suppression by default.
- **Possession:** Canadian data residency; add breach response with immediate community notification.
- **Consent:** Indigenous-specific options (community sharing, follow-up contact, traditional knowledge protection).
- **Review & Release:** Co-review any Indigenous-identified reporting with Indigenous leadership before release.
- **Beyond First Nations:** Respect Inuit and Métis data principles where applicable.

Operational Governance

Operational governance supports the safe, reliable, and accountable delivery of HMOC: Virtual MRP once services are implemented. Organizations should consider establishing clear processes for day-to-day operational oversight, decision-making, issue escalation, and resolution. Governance structures and accountabilities may vary based on local context, existing organizational structures, and the scope of the HMOC: Virtual MRP service.

Operational Governance Considerations:

When developing or adapting operational governance for HMOC: Virtual MRP, organizations may consider the following:

- **Timely decision-making:** Support decision-making at the appropriate level to promote patient safety and operational responsiveness.
- **Clear roles and escalation:** Establish clear roles, accountabilities, escalation pathways, and processes for modifying or pausing services when required.
- **Practical and scalable governance:** Design governance processes that are workable within local site capacity, resources, and existing organizational structures.
- **Consistency with local adaptation:** Support alignment and consistency where appropriate while enabling adaptation to local context and service needs.
- **Indigenous cultural safety and equity:** Embed Indigenous cultural safety, equity, and accountability within governance and decision-making processes.

Operational Governance for HMOC: Virtual MRP Services

Potential Governance Level	Illustrative Area of Focus	Potential participants	Illustrative Responsibilities and Considerations
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Site-Level Operational Governance	Day-to-day service delivery	• Site Operational Leadership (e.g., Site Director, Unit Manager) • Site Clinical Lead (Physician or NP with delegated authority)	• Day-to-day operations of HMOC: Virtual MRP Workflow adjustments within locally established parameters; patient assignment processes; immediate safety escalation and response; locally established processes for modifying or pausing • Patient assignment decisions Immediate escalation and safety response • Authority to pause or suspend HMOC: Virtual MRP services when safety concerns arise.
Regional /Health Authority Level Coordination	Cross-site coordination, resourcing, and service oversight.	• Relevant Regional or Health Authority operational, clinical, and virtual care leadership, as applicable	• Coordination of Virtual MRP resources and staffing; consideration of changes to service hours or scope through established organizational processes, escalation of issues that cannot be resolved locally; performance and workforce monitoring; coordination with relevant organizational functions for technology support and vendor/contract management, where applicable
Provincial-Level Coordination and Learning	Knowledge sharing, alignment, and opportunities for scale and spread	• Relevant Provincial, Health Authority, clinical, operational, and virtual care partners, as applicable	• Provincial policy, guideline, and playbook development/changes • Cross-health authority knowledge sharing and learning • identification of opportunities for alignment • sharing of emerging practices and implementation learnings Identification and escalation of system-level barriers and opportunities through appropriate channels • Consideration of future opportunities for provincial data aggregation and reporting

Workflow Mapping

Integrating virtual MRPs into onsite clinical environments will require careful consideration and unique workflows for each new site/clinical service & the accompanying technology. 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 and patient partners to co-design the workflows and transition plan 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 & patient partners 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 as the current state workflow will highlight the key workflow requirements when implementing HMOC: Virtual MRP. This is a wonderful opportunity to understand the current realities of staff and co-create the future with them, as well as understand the amount of change and readiness of the staff to go from current to future state.

Map Current State Workflow

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.

How to Complete Workflow and Process Mapping

1. Define the Scope and Objectives
 - Identify the process to be analyzed.
 - Clarify the purpose (e.g., efficiency, standardization, automation readiness).
2. Gather Information
 - Conduct interviews, observe workflows, review existing documentation, and gather any current diagrams or artifacts.
3. Map the Current State
 - Document all tasks, sequencing, decision points, tools used, and hand-offs.
 - Process maps communicate the workflow steps, roles involved, and key decision points, providing a clear visual representation from start to finish.
 - Arrival, Registration, Patient List/Waiting List, Triage, Intake, Admission, Assessment, Orders, Rounding, Documentation, Follow up, Handover, Discharge, Escalation
4. Analyze the Current State
 - Identify redundancies, bottlenecks, variations between sites, manual tasks suitable for automation, and inconsistent data practices.
5. Validate with Key Partners and Subject Matter Experts (SMEs)
 - Review and confirm accuracy and feasibility with end users, leadership, technical teams, and quality groups.

Illustrative Patient Journeys in HMOC: Virtual MRP

The following patient journeys show how HMOC: Virtual MRP may operate across inpatient, emergency department, and urgent primary care settings. They highlight potential points of virtual MRP involvement, collaboration between virtual and onsite teams, and key care transitions.

These examples are illustrative only and not intended as prescribed workflows. Virtual MRP involvement will vary based on the care setting, patient needs, local resources, and provider roles.

Across all models, patients and families should be informed when virtual care is used, understand the roles of virtual and onsite team members, and be supported to participate in care decisions. Local workflows should clearly define roles, accountability, handover processes, and escalation pathways in accordance with organizational and professional requirements.



Illustrative Case Example: Patient Journey Maps Inpatient Unit



Illustrative Case Example: Patient Journey Map Emergency Department



Illustrative Case Example: Patient Journey Urgent Primary Care

Benefits of Workflow & Process Mapping

- Visualizes the entire workflow from start to finish
- Standardizes processes across teams or sites
- Highlights roles and responsibilities
- Identifies inefficiencies, gaps, and opportunities for improvement
- Emphasizes critical decision points that affect outcomes or data flow
- Supports data-structure standardization and system configuration
- Ensures issues are addressed before automation or technology implementation

Tools and Resources for Workflow & Process Mapping

1. Flowcharts: Simple step-by-step depiction of workflow and decisions
2. Swimlane diagrams: Show responsibilities across roles or departments
3. Value Stream Mapping: Optimizes flow
4. Activity diagrams: Structured representation of workflow and decision logic
5. Data Flow Diagrams (DFDs): Map movement of data across systems and people

Map Future State Workflow

Develop future state workflow in collaboration with vendor and the following functions, at a minimum: clinical operations, clinicians, clinical informatics, Information Management & Information Technology (IMIT), patient partners and a MRP delegate. It is essential to include clinical operations, clinicians and MRPs throughout this process as they are key Subject Matter Experts (SMEs) in understanding the requirements and workflows. 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 including and not limited to:

- Virtual MRP practice

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

Considerations include:

- MRPs and clinician coverage shift schedule structure and back-up plans/escalation processes
- Baseline staffing levels
- Patient acuity
- 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
- Equipment and systems
- Credentialling, privileging, access and provisioning
- Provide an opportunity for consultation from all care staff who will touch that patient journey directly or indirectly (ex. Pharmacy, Physiotherapy, Occupational Therapy, Patient Care Coordinator, Discharge Coordinators, Indigenous Care Liaison etc.)
- Provide an opportunity for the MRP group to provide feedback
- Present workflows to the clinical working group and receive endorsement from clinical SMEs
- Be prepared to change workflows in the beginning stages of your HMOC: Virtual MRP pilot, employ multiple Plan-Do-Study-Act (PDSA) cycles with staff.
- Workflow option: In some settings, on-site nursing staff introduce virtual care interaction and document patient consent earlier in the visit (for example, during intake). At the start of the virtual encounter, the virtual MRP confirms consent and notes any relevant limitations or considerations.



Rural & Remote Spotlight: Low-resource staffing and surge risk

In lower-resource sites, the main risk is sudden increases in acuity or multiple simultaneous arrivals. Virtual workflows can add coordination time and slow throughput compared to independent in-person practice.

Design implication: Build workflows around safe workload limits (approx. 2 patients per hour). Reduce duplication (virtual provider reviews triage notes/assessment before entering encounter) and use streaming criteria so lower-acuity cases can be supported virtually when a comprehensive physical exam is not required.

Minimum safe standard: A defined “pause/suspend virtual service” workflow must exist and be practiced, including what happens to the in-progress patient and how the virtual provider is notified.

If/Then Adaptation: If staffing is single-nurse or nursing tasks pull the nurse away (IV meds, stabilization, time-consuming assessments), then limit virtual encounters to low-intensity nursing support and/or align virtual hours to known lower-acuity periods.



Accessibility & Communication Needs Checkpoint:

When future state mapping and prior to service launch, teams must confirm:

- Process to identify & and document patient accessibility, communication, and language needs at intake and before each virtual encounter, including:
 - Preferred language
 - Hearing, vision, speech, cognitive, or communication needs
 - Technology access and comfort
- Need for interpreters, captioning, assistive technology, or a support person
- Process for staff to arrange required supports.



Illustrative Case Example (Site-Specific Experience): Workflow Integration Lagged Behind Safety and Technology Confidence (LINK-ED)

In LINK-ED's first month, staff reported strong perceptions of technology reliability and patient safety, while integration into local workflows was more mixed. Only 50% of respondents agreed that “the model is well integrated with their site workflow,” while 90% agreed technology was reliable and 90% agreed patient safety has been maintained. Findings reflect responses from participants in the early LINK-ED implementation period and should be interpreted within that context.

These findings illustrate that technology, and safety confidence may be high, but workflow integration takes deliberate design work. Ongoing workflow refinement may help using rapid workflow iteration (PDSA), with a focus on documentation pathways, task clarity, and reducing extra steps for on-site teams.



Rural & Remote Spotlight (RSA): Small-site workflows

In practice, smaller-site workflows are often similar to larger sites. The key difference is not the steps—it's the fine-tuning based on local staffing, comfort level, and available resources.

Design implication: Always validate workflows with Subject Matter Experts (SMEs) and adjust what they identify. Fine-tuning is often minimal but essential for adoption and patient safety.

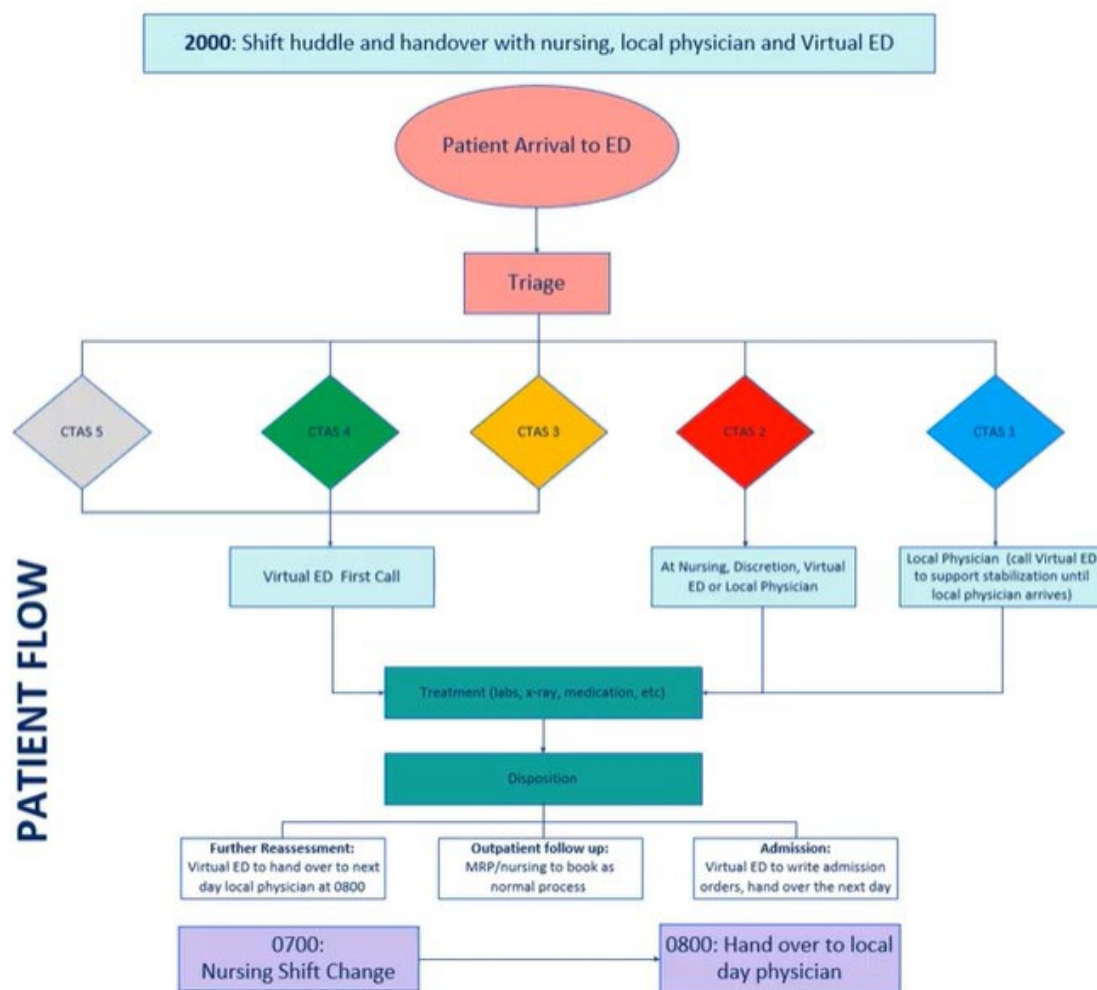
If/Then Adaptation: If a site requests local adjustments, then incorporate them quickly and visibly (PDSA cycles) to maintain trust and reduce resistance.



Illustrative Case Example: Emergency Department Future State Process Map

This process map is provided for illustrative purposes only. Future-state workflows should be adapted to local context, clinical requirements, available resources, and organizational processes.

Process Map for Virtual Hybrid Model 2000-0800

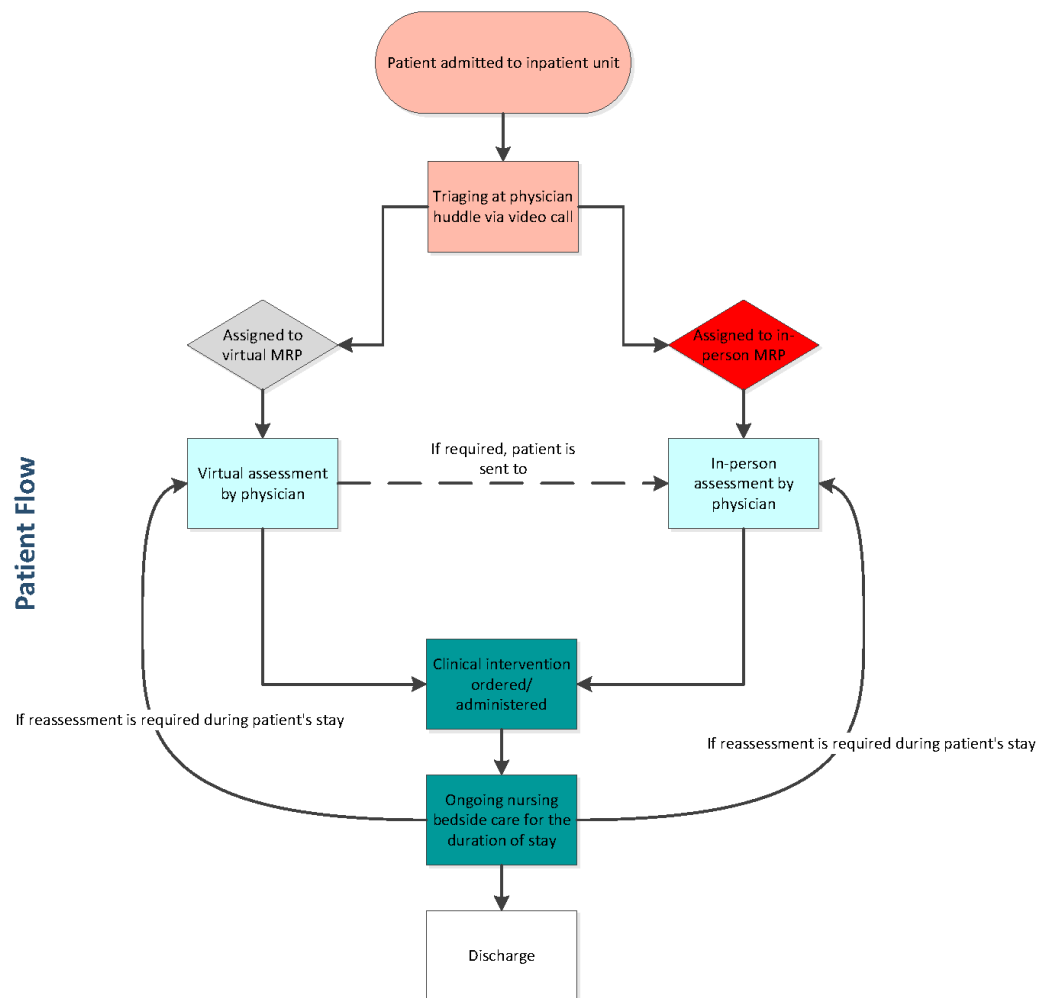




Illustrative Case Example: Inpatient Unit Future State Process Map

This process map is provided for illustrative purposes only. Future-state workflows should be adapted to local context, clinical requirements, available resources, and organizational processes.

Process Map for Virtual Hybrid Model - Inpatient Care

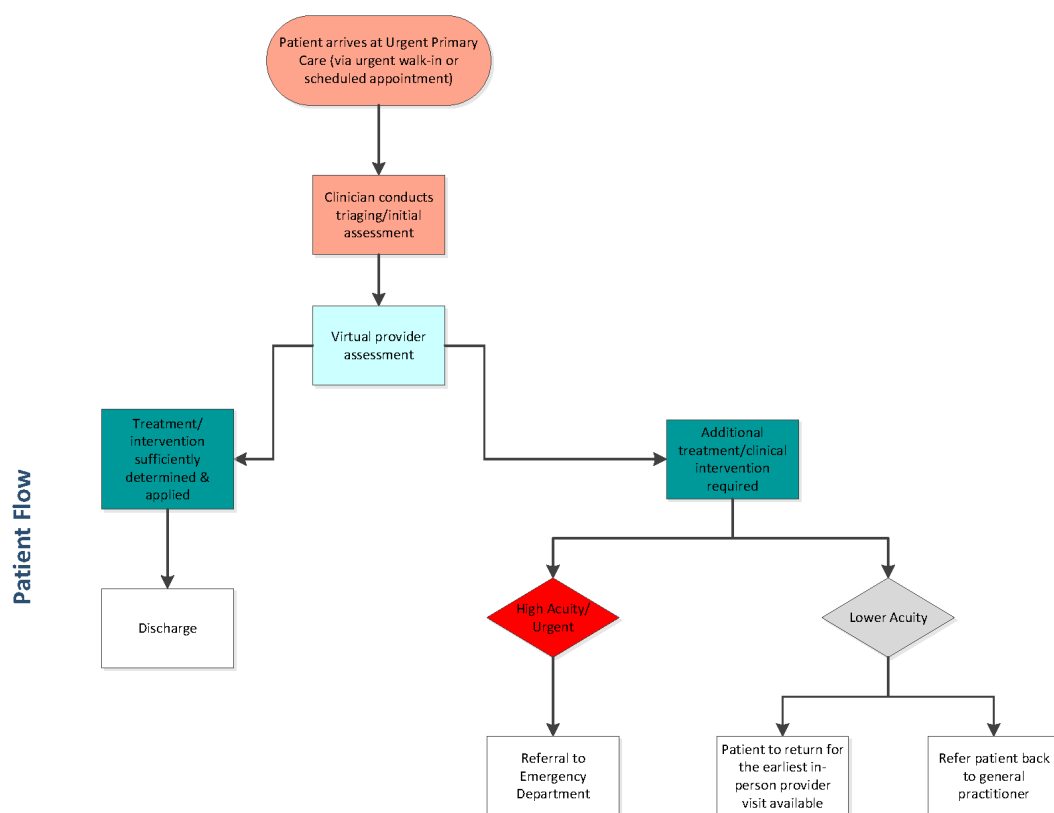




Illustrative Case Example: Urgent Primary Care Future State Process Map

This process map is provided for illustrative purposes only. Future-state workflows should be adapted to local context, clinical requirements, available resources, and organizational processes.

Process Map for Virtual Hybrid Model - Urgent Primary Care



Orders, Results, and Follow-Up

Each HMOC: Virtual MRP site must explicitly define:

- Who is responsible for following up on labs, imaging, and consults ordered by a virtual MRP
- What happens when there are staffing gaps in lab and medical imaging and contingency plans
- How results are monitored once the virtual provider's shift ends

- How patients without a primary care provider are supported for post-visit follow-up
- Results or reports (“results”) must be delivered to the provider and location where the test or intervention was originally ordered. Delivery is based on the clinical context, including time of order, ordering provider, and the department listed on the requisition.
- If additional clinicians should receive results, prescribers must indicate the primary receiving location and any copy recipients on the requisition.
- Results are directed to health-care providers either because they ordered the intervention and are responsible for review, or because the ordering provider requested that a copy be sent to them.
- Prescribers including physicians, medical trainees, nurse practitioners, clinical assistants, and other regulated health-care professionals order diagnostic tests and interventions. Results are returned to the responsible prescriber. The attending prescriber is typically contacted first, but the ordering prescriber (or on-call delegate) may also be contacted. Prescribers must maintain clear, up-to-date pathways for receiving critical results and ensure these pathways are known to their facilities.
- If results should be directed to another prescriber (e.g., family physician or consulting specialist), that individual must be added to the copy list at the time of ordering. When patients undergo testing at another facility before returning to the ED, results generally return to the ordering prescriber and may also be copied to the authorizing prescriber.

These accountabilities should be documented in site protocols and reinforced during training.



Illustrative Case Example: Community Pharmacy Prescription Confirmation and Issue

Resolution

In some urgent primary care workflows, prescriptions are transmitted to a community pharmacy using fax or secure electronic methods. When transmission fails or is delayed, patients may return to the site or seek reassessment in the ED to resolve the issue. A local workflow can outline how prescription transmission is initiated and recorded, how successful transmission is confirmed where feasible, what patients receive at the end of the visit to support follow-through if the pharmacy reports a delay or non-receipt, and how the site team re-routes or resolves prescription issues when they are identified. This workflow is site-specific and supports continuity when prescription delivery depends on external systems. Processes should be adapted to local workflows, available technology, organizational requirements, and applicable professional and regulatory requirements.

Evaluation Planning

The provincial evaluation framework provides a common foundation for evaluating HMOC: Virtual MRP across health authorities, while allowing flexibility to address local context and program needs. A consistent set of provincial core indicators, definitions, and feedback mechanisms supports comparability, shared learning, and provincial monitoring, while health authorities may identify additional measures relevant to their populations, service models, and implementation contexts. The provincial evaluation framework is an offering to health authorities with recommended metrics for reporting and evaluating virtual and hybrid services across programs (primary, specialty, acute-substitution, mental health, rural/remote). Health authorities are responsible for developing a

comprehensive evaluation plan aligned with the Provincial HMOC: Virtual MRP evaluation framework for quality assurance.

Evaluation Activities

1. Evaluation planning

- **Patient, Family and Caregiver Partnership:** Meaningfully involve patient partners, families, and caregivers, as appropriate, in the design, implementation, and evaluation of HMOC: Virtual MRP. Engagement should extend beyond initial consultation to ongoing co-design, interpretation of findings, identification of improvement opportunities, and refinement of the model throughout implementation.
- **Governance:** Establish a clear governance structure that identifies decisionmakers, roles, and reporting pathways to ensure accountability and transparency. This includes confirming who oversees evaluation activities, who approves methodological changes, and how results will be communicated.
- **Program objectives and scope:** Define the purpose of the virtual or hybrid care program, including the populations served, care settings involved, and the specific pathways being evaluated (e.g., conditions, modalities, escalation rules).
- **Theory of change & logic model:** Develop a logic model outlining the key inputs, activities, and expected outcomes, ensuring alignment between program intentions and evaluation measures. This provides a shared understanding of how virtual/hybrid care is expected to produce meaningful change. It also guides indicator selection and supports transparent interpretation of results.
- **Ethics and Quality Review:** Complete an ARECCI or similar screening as appropriate. Ensure privacy, cultural safety, and Diversity, Equity, and Inclusion (DEI) principles are reflected in data collection and reporting. Align consent processes for patient surveys and Most Responsible Provider (MRP) interviews or focus groups.
- **Evaluation rubric:** Create an evaluation rubric that describes criteria for success, acceptable performance ranges, and thresholds that trigger follow-up or improvement actions.

1. Data collection

- **Patient and Family Feedback Mechanisms:** Establish consistent and accessible mechanisms for obtaining patient, family, and caregiver feedback throughout implementation. This may include standardized Patient-Reported Experience Measures (PREMs), brief post-encounter surveys, qualitative interviews or focus groups, and other locally appropriate approaches. Feedback should be reviewed at defined intervals and incorporated into continuous improvement and model refinement.
- **Define data sources:** Identify and document all relevant data sources, including EMR/EHR records, virtual platform analytics, scheduling systems, PREMs, staff feedback, interpreter logs, safety event systems, and operational/cost datasets. Programs may also build specific

analytic flags—such as a Virtual/Hybrid Service (VHS) exposure flag (based on roster + Mon–Fri 08:00–16:00 availability) or a temporary “fully virtual” flag during special service periods—to support consistent measurement.

- **Baseline measurement:** Capture baseline values for key indicators (e.g., access, safety, experience, equity, appropriateness, outcomes). Establish definitions, methods, and data owners prior to launch.
- **Measurement plan:** Develop a plan that identifies which patient, MRP, operational, and safety measures will be collected.
 - Use validated tools where possible, including EQ-5D-5L and BC Patient-Centred Measurement (BCPCM) PREMs. This may be supplemented with short pulse surveys (2–5 questions) after visits to assess communication, modality choice, and cultural safety, with integration into the DART where available. Consider eligibility and timing and reduce reliance on direct care staff to minimize burden and bias.
 - MRP feedback channels: Early and year-end focus groups; anonymous open-ended survey.

2. Data Analysis

- **Define comparison groups:** Identify appropriate comparison groups such as matched virtual/hybrid vs. in-person cohorts for relevant condition bundles during the implementation year, ensuring comparability. Where useful, incorporate fully virtual service periods or a pre-implementation baseline year to understand operational and utilization trends.
- **Statistical methods:** Apply appropriate statistical tests based on data type, e.g., Wilcoxon rank-sum for continuous variables and Fisher’s exact test for categorical variables (two-tailed or one-tailed depending on pre-specified hypotheses), with suppression of cells <5 to protect privacy. Use p-value thresholds (e.g., 0.05/0.10) transparently and complement them with time-series methods such as run charts or simple statistical process control (SPC) to identify trends and shifts over time.
- **Stratification for Equity:** Review indicators across key demographic and contextual variables, such as rurality, age, language, and disability to identify inequities in access, experience, or outcomes.
- **Triangulate Multiple Data Types:** Combine quantitative findings (e.g., utilization, outcomes, returns) with qualitative insights from PREMs comments, provider reflections, or focus group themes

Recommended Evaluation Data Points

The framework is aligned with the Quintuple Aim, Benefits Evaluation framework, 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 are asked to collect both standard provincial metrics, and any additional data based on local needs. Health authorities are asked to provide data to the Ministry of Health, or its delegate, with data upon request.

*Programs vary in scope, and not all indicators or data elements will be feasible or available to report at every site.

Province-wide Core Evaluation Indicators (all care areas)

Domain	Indicator	Definition (what you report)	Data Source
Access & timeliness	Time to clinician initial assessment	Median & 90th percentile from first clinical contact/registration to clinician initial assessment	EHR timestamps nightly ETL to analytics platform.
	Access to care for underserved populations	Utilization rates for virtual/ hybrid appointments stratified by age, rurality, language, socioeconomic indicators, digital access.	PREMs, registration data
Patient safety	Unplanned escalation	% virtual encounters requiring onsite urgent assessment or transfer within 24–72 hours	EHR events + site incident system
	Safety events	Number and type of clinical, technical, or privacy-related safety events	IT incident logs, EHR, Site incident system; PSLs
Clinical effectiveness	Order-to-action cycle time	Time from MRP order placement to action/result acknowledgement; track abnormal result follow-up closure	EHR order/result logs; automated extracts.
	Readmission/ Return visits	% of repeat visits within 7 or 30 days for same issue	
Appropriateness	Modality appropriateness	% of visits where chosen modality aligns with clinical need	Provider surveys; EHR modality flags
Patient experience	Communication & satisfaction	% top-box on communication, technical ease, shared decision-making, understanding next steps (telehealth-adapted CAHPS C&G constructs)	PREMs (BCPCM or program surveys)
	Cultural safety, respect and dignity; person-centered approach	Patient-report of being treated respectfully, safely, and without discrimination during virtual/hybrid care.	PREMs (BCPCM cultural-safety items); Program surveys
Provider experience	Ability to provide safe, effective care	Provider perception of whether the encounter allowed appropriate assessment, safety checks, and clinical decision-making.	Provider surveys; structured debriefs; chart audits
	Impact on Well-Being & Workload	Provider-reported workload, burnout risk related to virtual/hybrid care.	Provider wellbeing surveys

Domain	Indicator	Definition (what you report)	Data Source
		Median nursing/admin minutes spent on device setup, order relay, interpreter coordination	Task capture (light time-motion 1 week/quarter)
Efficiency	Diversions/transfers avoided & virtual shift fill rate	Count avoided site diversions/transfers where virtual coverage enabled care; % planned virtual shifts filled	Operations logs; vendor staffing /availability feeds;
Technology use and support	Technical Success Rate	% of visits successfully completed without major connectivity, audio, or video failures. High-priority incidents rate and time-to-resolve; % staff completing mandated training (workflow, privacy, ISAR)	Platform analytics, IT logs
	Workflow Integration	% of visits where providers document adherence to virtual workflow steps (privacy, consent, documentation standards). Provider ease with virtual/hybrid workflow including accessing EMR, virtual technology, etc	EHR audits, provider self-report

2) Province-wide ISAR Core (required in all care areas)

ISAR domain	Operational indicator	Experience indicator (ICS)	Data source
Relationship-based care	% visits with relation-building step recorded (who to involve; introductions)	Top-box: provider took time to build trust before care	ICS PREM module;
Identity	% Indigenous patients with safe, voluntary self-identification recorded	Top-box: my identity was respected and safe to share	Registration field with governance; ICS survey
Self-determination & equity	% Indigenous patients offered modality and family/Elder presence; % interpreter used when preferred; navigator involvement	Top-box: I had a say in how care was delivered	Intake preferences; Language Services logs; ICS PREM
Respect	% charts with preferred name/pronunciation documented	Top-box: I was treated with respect	Smart phrase in notes; ICS PREM
Access	Virtual completion rate: Indigenous vs non-Indigenous;		PREMs, registration data
Discrimination & harm response	Racism incidents reported, time-to-first response, % with feedback loop closed	Top-box: I knew how to report racism and felt safe to do so	Simple e-form + case tracker; monthly review with partners

3) Add-on Indicators by Care Area

3A) Emergency Department (in addition to province-wide core)

Domain	ED-specific indicator	Definition	Data source & automation
Access & timeliness	Time to PIA by CTAS (median/90th)	Use CIHI method; stratify by CTAS 1–5; report by shift/day.	EHR; nightly ETL.
Safety	72-hr ED return after discharge (virtual MRP)	% of ED discharges with same-issue return ≤ 72 h.	EHR linkage; monthly.
Effectiveness	Time to first order & result acknowledgement	Consult/assign $\rightarrow$ first order; result posted $\rightarrow$ acknowledged.	Order/result logs; nightly.
Onsite workload	Nurse minutes per virtual ED case	Device/peripheral setup, order relay, interpreter coordination.	Task capture (sampled week/quarter).
ISAR in ED	Family/Elder presence invited when desired; interpreter used	% Indigenous patients with offer recorded; % interpreter utilization when preferred.	Intake/triage fields + Language Services logs; monthly.

3B) Inpatient (in addition to province-wide core)

Domain	Inpatient-specific indicator	Definition	Data source
Access & continuity	Consult request $\rightarrow$ virtual connect time	Minutes from consult entry to first virtual assessment.	EHR consult log + vendor session start; nightly.
Safety	RRT within 24h of virtual consult	% consults followed by Rapid Response Team ≤ 24 h (contextual safety signal).	EHR/incident system; monthly.
Effectiveness	Length of stay (LOS)	Risk-adjusted LOS for patients managed virtually vs. onsite.	EHR; quarterly analytic refresh.
	Readmission rate (30 days)	% of patients readmitted to hospital within 30 days.	EHR; quarterly analytic refresh.
ISAR in inpatient	Family/Elder/Knowledge Keeper participation	% virtual rounds where invited party attends when desired.	Rounds checklist; monthly.

3C) Primary Care (UPCC/PCN/longitudinal) (in addition to province-wide core)

Domain	Primary care-specific indicator	Definition	Data source
Access & continuity	Time to next appointment (virtual vs. in-person)	Days to next available slot; report by modality.	Scheduling/EMR; weekly.
Appropriateness /safety	Same-issue ED visit ≤ 72 h post virtual visit	% virtual visits followed by ED visit for the same issue.	EMR–ED linkage; monthly.

Domain	Primary care-specific indicator	Definition	Data source
Patient experience	Most-recent-visit telehealth items + overall rating	CAHPS-aligned short set; add narrative prompt.	SMS PREM; weekly ingestion.
Provider load	After-hours message load per FTE	Messages 18:00–08:00 per provider FTE.	Messaging logs; monthly.
ISAR in primary care	Preferred modality honored; plain-language summary sent; interpreter used	% Indigenous clients with chosen modality delivered; summary provided; interpreter used when preferred.	EMR templates + Language Services logs; monthly.

Additional Evaluation Considerations

- **Evaluation Working Group:** Membership should include operational leaders, clinical leaders, digital health/IT, quality and safety specialists, evaluation and analytics experts, patient partners, Indigenous engagement advisors, and representatives from each participating site or health authority.
- **Evaluate at multiple timepoints:** Conduct evaluation at defined intervals—such as 3, 6, and 12 months—to answer different types of evaluation questions. Early (3-month) reviews help identify implementation issues, workflow challenges, and data quality needs; mid-point (6-month) reviews assess emerging trends in access, safety, and experience; and annual (12-month) evaluations support outcome analysis, equity review, and decisions regarding scale-up or redesign.
- **Data Governance and Stewardship practices:** Clarify data access, ownership, privacy protections, and approval processes for shared reporting. Patient engagement and any data collection follow the governance of OCAP®, OCAS®, and Inuit Qaujimajatuqangit principles
- **Provincial Learning and Knowledge Sharing:** Establish mechanisms for participating sites and health authorities to share evaluation findings, patient and provider feedback, implementation lessons, and emerging practices. Consistent reporting and cross-jurisdictional knowledge sharing can support continuous improvement, identify common and context-specific challenges, and inform the ongoing evolution of HMOC: Virtual MRP across the province.

Illustrative Examples Only: The evaluation frameworks below are provided as examples of approach and structure only and are not intended for direct reuse or adoption. Organizations should develop evaluation frameworks appropriate to their local context and governance requirements.



Illustrative Case Examples: Sample Evaluation Frameworks & Reports

- Interior Health Inpatient Evaluation Framework quick glance
- Interior Health LINK-ED Evaluation Framework
- Northern Health Evaluation Framework

HMOC: Virtual MRP 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.

- Probability reflects how commonly the risk has been observed in HMOC: Virtual MRP or similar virtual care implementations.
- Impact reflects the potential effect on patient safety, service continuity, staff workload, or adoption if the risk is not mitigated.

Risk	Probability	Impact	Mitigation Strategy
Disagreement among key partners or leadership	Medium (Probability increases in sites with limited prior collaboration between operational, medical, and digital health leadership)	High (Can delay decisions and weaken implementation momentum)	Facilitate early and ongoing partner engagement; use structured decision-making frameworks and consensus-building tools.
Medical leaders failing to see the value in virtual care models	Medium (Varies by specialty culture and prior experience with virtual care)	High (Limits physician engagement and weakens clinical governance)	Engage medical leadership early on in the planning process and provide examples of quality/safety care in settings similar to theirs
Limited clinical staff endorsement	High (Frontline concerns about workload and safety are common)	High (Affects workflow reliability, morale, and adoption)	Engage clinical champions early, this includes MRPs, nurses, clerical staff, etc. Provide clear evidence of benefits and safety; offer training and feedback loops.
Insufficient local MRP staffing	High (Underlying condition prompting HMOC: Virtual MRP use at many sites)	High (Direct risk to service continuity and patient safety)	Use hybrid models with virtual MRP support; coordinate with locum programs; explore shared regional coverage.
Technology requirements not met	Medium (Infrastructure gaps persist in some rural or remote sites)	High (Technology failure can halt or compromise care delivery)	Conduct early tech assessments; secure funding for upgrades; ensure vendor support and interoperability.
Technology useability challenges	High (Early workflow and platform issues are common)	Medium to High (Sustained issues increase workload and frustration)	Ensure all virtual care technology is connected, functioning properly, and that in-person staff are trained to

Risk	Probability	Impact	Mitigation Strategy
			use it to avoid delays in patient care.
Administrative barriers to system access	High (Credentialing and access processes are complex)	Medium to High (Delays can create inefficient or unsafe workarounds)	Streamline provisioning processes; establish clear protocols for access; engage IT and privacy teams early.
Distrust between virtual and in-person clinicians	Medium to High (Trust takes time without shared working experience)	High (Leads to duplication, delays, and team conflict)	Build trust through team huddles, joint case reviews, shared protocols, and regular communication; promote team-based care culture inclusive of MRPs, nurses, allied health, and support staff.
Limited engagement with patient and Indigenous partners	Medium (Engagement may be constrained by timelines or capacity)	High (Affects cultural safety, equity, and community trust)	Allocate dedicated resources for engagement; use culturally safe approaches; co-design with community representatives.
Increased diagnostic service demand to support virtual MRP assessment	Medium (Virtual assessment may increase early diagnostic reliance)	Medium (Usually manageable but may strain small sites)	Monitor diagnostic utilization; adjust workflows; ensure capacity planning includes diagnostic services.
Increased nursing workload to support virtual MRP assessment	High (Virtual workflows rely heavily on nursing support)	High (Contributes to burnout and sustainability risk)	Design workflows to balance tasks; provide support staff; monitor workload and adjust staffing as needed. Consider adequate nursing support to accompany the virtual MRP.
Accessibility challenges	Medium (Not universal but regularly encountered)	High (Impacts consent, safety, and equity obligations)	Confirm that accessibility supports—such as interpretation services and Indigenous patient navigation—are integrated into the care model.
Unclear clinical accountability and decision authority	Medium (Hybrid roles are new pre-launch)	High (Safety and medico-legal risk)	Define MRP accountability, escalation authority, and pause criteria in a one-page governance summary
Required protocols not finalized or socialized	Medium (Often assumed rather than confirmed)	High (High risk scenarios unmanaged)	Finalize and approve protocols for deterioration, provider disagreement, and technology failure before launch

Risk	Probability	Impact	Mitigation Strategy
Technology readiness not fully validated	Medium (Last mile issues common pre-launch)	High (Inability to safely deliver care)	Complete end-to-end testing, downtime scenarios, and device readiness checks prior to go live
Staff not adequately oriented to HMOC: Virtual MRP workflows	High (Mixed rotations and turnover)	Medium to High (Inconsistent practice and errors)	Require just in time orientation, role clarity, and simulation before first HMOC: Virtual MRP shift
Consent and patient communication approach not standardized	Medium (Workflow variation pre-launch)	High (Legal, ethical, and trust risk)	Implement standardized consent script and documentation process before first patient encounter

Section 4: Implementation Preparation (Including Site Visits)

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 and/or Exploration 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: Virtual MRP 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.



Illustrative Case Example (Site Specific Experience): Interior Health Virtual Hybrid Care Model Project Virtual Kick Off Slide Deck



Illustrative Case Example (Site Specific Experience): Northern Health Virtual Hybrid Emergency Department Models of Care Exploration Meeting

Site Visits

In preparation for launching HMOC: Virtual MRP, 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 MRP 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), nursing educator, nursing union rep
 - Floor nurses
- MRP reps:
 - Hospitalist/ED MRP/Nurse practitioner
 - Chief of Staff
- Leadership:
 - Site director of operations
 - Executive director of the region
 - Physician leadership

- Broader Health Authority support team: Digital Health and Clinical Informatics (physician support specialist), Quality and Improvement Rep, Communications, Professional Practice
- Local patient partner (s)
- Provincial Virtual Health (PHSA)
- Vendor (if applicable)

Site & Community Context Validation (Required in Site Visit 1):

During the walk-through, validate and complete the Clinical Site Detail Page and confirm how virtual providers will access:

- Diagnostics availability and hours (lab/DI), pharmacy access, and after-hours contacts
- Referral options and local services (Pathways or local equivalent)
- Escalation contacts, transfer pathways, and known constraints (e.g., transport delays)
- Cultural supports and access supports (Indigenous Patient Navigation, interpretation process, accessible communication needs)

Output by end of Site Visit 1:

- Validated future state workflow
- A finalized (or updated) Clinical Site Detail Page and a confirmed referral directory link/process.



Template: Clinical Site Details



Illustrative Case Example: Perceived Nursing Workload Shift During Early Hybrid

Implementation (LINK-ED)

During LINK-ED's first month, staff feedback included both benefits and concerns, including perceptions of changing workload distribution across the care team. "I see patient care reduced, and nursing workload and responsibility increased."

This example reinforces the importance of designing workflows that reduce administrative burden and avoid unintended task shifting to nursing. Sites should proactively map "who does what," streamline documentation and order routing, and monitor workload signals during soft launch.

Site Visit 2: Training and Preparation for Soft Launch

Consider including the following activities:

- Technology "testing" (ensuring connectivity throughout the healthcare site) 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: Virtual MRP 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

Training and Education

Developing a training and education plan

Education and training are required for all staff involved in the patient journey, as well as for patients themselves. Patients must understand hybrid care and be able to provide informed consent. Staff must be prepared not only to implement hybrid services but also to confidently support patients throughout their care experience. Virtual MRPs must be able to deliver safe, effective care and understand the local site and community context in which they practise.

Education for Hybrid Models of Care is well suited to a standardized approach, particularly where clinicians support multiple sites or regions. Recognition of equivalent training completed elsewhere can reduce duplication while supporting consistent understanding. The Provincial HMOC: Virtual MRP Education Guides for virtual providers, onsite staff (including nursing, allied health, administration, and leadership), and patients and families are intended to define minimum training standards and provide base content for sites to adapt into site-specific education.

Team Competencies and Virtual Care Readiness

Defining Team-Based Competencies

Successful Hybrid Models of Care require more than physician coverage and technology. The safety and effectiveness of HMOC: Virtual MRP depends on the collective competencies of the entire care team and the alignment between the capabilities of onsite staff and virtual providers. Staffing readiness should include assessment of experience, training, confidence, and scope of practice—not simply staffing levels.

Organizations should assess and document:

Competency Area	Onsite Team	Virtual Physician/NP
Patient assessment	Physical assessment, monitoring, recognition of deterioration	Virtual clinical assessment and decision-making
Communication	SBAR communication, escalation, handovers	Remote communication and shared decision-making
Technology	Device operation, peripherals, troubleshooting	Video platform, EMR (if appropriate), remote diagnostics
Clinical escalation	Emergency response, stabilization, transfer processes	Escalation decision-making and clinical leadership
Team-based care	Collaboration with virtual providers	Collaboration with onsite teams
Cultural safety	Local context and relationships	Virtual culturally safe care delivery



Resources: Provincial Hybrid Model of Care Education Guides:

- Hybrid Mode of Care Patient and Family Education Guide – coming soon
- Hybrid Model of Care Onsite Staff Education Guide – coming soon
- Hybrid Model of Care Virtual Provider Education Guide – coming soon



Rural and Remote Spotlight: Readiness

Readiness includes confidence and competencies. Staffing readiness is not only headcount. It includes nurse staff experience, training, and comfort level operating at the site's edge of care.

Design implication: Assess readiness case-by-case with the local nursing team. Expect a wide range of comfort levels and treat those signals as design requirements.

Site Champions

Site champions are onsite staff, leadership, and patient partners who are onboarded as change champions. These are the people who are at 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.

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 and A about the service
- Patient brochure and poster
- Escalation pathway document
- Nurse script
- Provide T-shirts to wear during site visit 2 and during the pilot launch to make them easily identifiable



Template: Site Champion & Information Booth Package

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.), an information booth set up in a central location with information and a site champion to speak to the service is recommended.

Materials to support the information booth:

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



Illustrative Case Example: Site information booth at Cariboo Memorial Hospital

Communications

- Receive and disseminate endorsement and communication of support from site/health authority leadership (e.g. letter of endorsement from Vice President)
- Send out staff memo
- Prepare for media briefings
- discuss communication with the community - social media, local media, PSAs, interviews for radio and TV. Be transparent about staffing challenges and ongoing efforts to address this

Reach out to community partners re: the pilot launch and impact on the community, solicit feedback from various channels.

Escalation Protocols

Escalation protocols enable timely, appropriate responses to clinical concerns in a hybrid model of care (HMOC) Virtual MRP. They must be defined, validated, and communicated before go-live to support patient safety, reduce delays in care, and build confidence among onsite teams and virtual providers. All staff—virtual and in-person—must understand when and how to escalate concerns.

Clinical Accountability in Hybrid ED Care

Clinical accountability is reinforced through onboarding, written workflows, and routine operations.

Core elements include:

- Clear identification of the Most Responsible Provider (MRP) at all times (virtual or onsite)
- Accountability of the virtual physician for clinical decisions, orders, and documentation while under their care
- Responsibility of onsite teams for hands-on care, monitoring, and initiating escalation
- Defined escalation pathways outlining when bedside backup is required and who assumes in-person responsibility
- Consistent communication practices, including huddles and standardized handovers

Escalation Framework

Example escalation framework documents complementary responsibilities for onsite staff and virtual providers and must be contextualized and validated locally for each HMOC: Virtual MRP site.

****Escalation is expected, supported, and essential to patient safety. It is used to promote shared awareness, timely response, and collaborative decision-making not to assign blame. Clinical judgment remains central in all situations.**

The framework supports hybrid specific coordination, including:

- Who to contact and how to escalate
- Handover and shared decision-making considerations
- Backup and downtime procedures
- Situations that prompt a pause or transition to in-person care

This framework functions alongside existing site policies, local clinical pathways, and emergency response procedures, which continue to apply.

Escalation Trigger	Example Indicators	On-Site Staff Responsibilities	Virtual Provider Responsibilities	Authority, Ownership & Timing
Immediate Clinical Risk	Airway, breathing, or circulation compromise; cardiac or respiratory arrest; rapid deterioration	Recognize deterioration; activate Code Blue or site emergency response; initiate hands on interventions within scope; communicate status to Virtual MRP	Confirm emergency response activation; provide real time clinical leadership; determine need for urgent transfer; remain connected until in person care assumes responsibility	Clinical authority: Virtual MRP; Operational activation: On-site staff; Timing: Immediate (minutes)
Clinical Deterioration or Increasing Acuity	Worsening vitals; escalating pain or distress; change in level of consciousness; clinical uncertainty	Identify change through direct assessment; escalate promptly to Virtual MRP; request in-person assessment or transfer support	Interpret delegated assessments; decide whether care can continue virtually; escalate to onsite/on call physician or initiate transfer; document rationale	Escalation decision: Virtual MRP; Trigger recognition: On-site staff; Timing: Urgent (same shift)
Scope of Practice or Clinical Disagreement	Orders exceed scope; disagreement about care plan; unclear accountability	Identify scope or safety concerns; communicate using SBAR; escalate to Site Clinical or Operational Lead if unresolved	Ensure care plans align with actual onsite scope and staffing; modify orders; escalate unresolved issues to leadership	Clinical responsibility: Virtual MRP; Safety advocacy: On-site staff; Timing: Same shift
Technology Failure Affecting Care	Loss of video/audio; EMR access	Identify and report technology issues; implement backup	Assess impact on clinical safety; determine	Authority to pause HMOC: Virtual MRP;

Escalation Trigger	Example Indicators	On-Site Staff Responsibilities	Virtual Provider Responsibilities	Authority, Ownership & Timing
	issues; peripheral device failure	communication as directed; escalate to IT or site leadership	appropriateness of alternate modality; pause or stop virtual care if unsafe	Operational escalation: On-site staff; Timing: Immediate–urgent
Diagnostic or Follow Up Accountability Gaps	Unclear responsibility for results; pending labs or imaging across shifts; risk of missed follow up	Flag unclear follow up responsibilities; ensure handover to next on shift team; escalate recurring gaps	Clarify and assign follow up responsibility; ensure continuity across shifts; escalate systemic gaps to HMOC: Virtual MRP leadership	Follow-up accountability: Virtual MRP; Handover support: Onsite staff; Timing: Same shift or within 24 hours
Safety, Cultural Safety, or Equity Concerns	Near misses; racism or discrimination; barriers to communication or consent	Identify and raise concerns in real time; ensure immediate patient safety; initiate incident reporting and supports	Take concerns seriously regardless of direct observation; adjust care approach; support escalation to Indigenous Health, leadership, or quality processes	Shared responsibility; Timing: Immediate or same shift
Staffing or System Limitations	Insufficient skill mix; inability to safely carry out virtual orders; competing clinical demands	Identify unsafe conditions; escalate to Site Operational Lead; advocate for workload adjustment or pause	Assess whether conditions support safe virtual care; modify or defer care plans; pause or exit HMOC: Virtual MRP when risks persist	Authority to pause/exit HMOC: Virtual MRP; Operational escalation: On-site staff; Timing: As soon as identified



Template: HMOC Virtual Acute Care Escalation Process



Illustrative Case Example: Common Reasons for Escalation/Transfer in Virtual ED Care

Teams using virtual ED care frequently describe escalation or transfer for reasons such as:

- Clinical deterioration or higher acuity than can be safely managed virtually
- Need for hands-on procedures (e.g., airway management, procedural sedation, complex wound care, fracture reduction)
- Limited onsite diagnostic or treatment capability
- Time-sensitive conditions (e.g., suspected stroke, STEMI, sepsis, major trauma)
- Pediatric or obstetric complexity beyond local capability
- Behavioral health or safety situations requiring onsite resources not available

Go/No-Go Decision for Pilot Launch

The Go / No-Go decision is a formal safety and readiness checkpoint completed immediately prior to pilot launch. Its purpose is to confirm that minimum clinical, operational, technological, equity, and governance conditions are in place to safely initiate Hybrid Models of Care (HMOC) Virtual MRP.

Decision owners (joint):	Site Clinical Lead & Site Operational Lead
Required inputs:	• Project Lead • Virtual Operations Lead • Nursing & Physician leadership • Digital Health / IMIT • Indigenous Health

Domain	Minimum Go Criteria (Must Be True)	Conditional Go (Allowed with Mitigation)	No-Go (Launch Must Pause)
Clinical Safety & Escalation	Escalation pathways documented and tested; onsite team capable of immediate stabilization; authority to pause HMOC: Virtual MRP defined	Escalation tested but staff confidence low; enhanced support planned	Escalation unclear or untested; no pause authority
Workforce & Role Clarity	MRP privileging & credentialing complete; roles accepted; contingent coverage plans in place	Short-term staffing gaps with back-up plan	Privileging & credentialing incomplete; role confusion
Orders & Follow-Up	Clear ownership for labs, imaging, follow-up	Manual workaround documented	Follow-up responsibility unclear
Technology & Connectivity	Video/audio tested; backup tested; system access confirmed	Minor issues with live IT support	Backup not tested; access incomplete
Governance & Authority	Named leads with decision authority; escalation defined	Governance exists but requires refinement	No clear authority or escalation

Domain	Minimum Go Criteria (Must Be True)	Conditional Go (Allowed with Mitigation)	No-Go (Launch Must Pause)
Equity & Cultural Safety	Interpretation tested; Indigenous navigation pathways known	Supports exist but refresher training needed	Interpretation unavailable; no escalation pathway
Training & Readiness	Orientation and simulation complete	Training complete but limited practice	Staff not trained



Checklist: Pilot Launch Checklist

Section 5: Pilot Launch

Overview of Pilot Phases

The HMOC: Virtual MRP pilot includes two operational phases:

1. Soft Launch – controlled, high-support introduction of the model
2. Full Launch – transition toward future-state operations

Progression between phases is deliberate and criteria-based, not time-based.



Template: HMOC: Virtual MRP Pilot Launch Checklist

Soft Launch

The soft launch introduces HMOC: Virtual MRP in a controlled, lower-risk manner, allowing teams to validate workflows in real clinical conditions, identify and correct issues early, and build confidence and trust between virtual and on-site teams.

During the soft launch, volumes, hours, or scope may be intentionally limited; enhanced support is available in real time; and daily learning and iteration are expected and encouraged.

Soft Launch Support Model

Clinical support includes direct access to clinical leads, daily start- and end-of-shift huddles, and active use of escalation pathways.

- Operational support includes at-the-elbow support from the project team, virtual operations, and Digital Health/IMIT, with rapid troubleshooting and visible decision-making authority.
- Technical support includes real-time IT support and live testing of backup modalities as needed.
- PDSA Cycles start and include daily issue logging, trouble shooting, and active solicitation of staff and patient feedback.

Full Launch

The full launch represents a transition toward the intended future-state model, where HMOC: Virtual MRP operates as a routine part of care delivery.

Full launch is appropriate when:

- Core workflows function reliably without constant intervention
- Staff demonstrate confidence in patient assignment, escalation, and documentation
- Technology issues are infrequent and manageable through standard channels
- Roles and decision authority are clearly understood
- There are no unresolved safety concerns.

During full launch, HMOC: Virtual MRP operates at the approved scope, hours, and volumes, and support shifts from at-the-elbow to scheduled, virtual, and escalation-based support.

Authority to Pause or Step Back

At any point during the pilot, HMOC: Virtual MRP may be paused, scaled back, or reverted if safety thresholds are met. Any team member may raise a concern. The Site Clinical Lead and Site Operational Lead have authority to act immediately. Pausing is a protective action, not a failure.

Develop and Initiate Support Plan

Initiate and activate site support plan for go-live, stabilization, and sustainment/optimization



Template: HMOC: Virtual MRP Pilot Support Plan Template

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.
- Set up weekly Community of Practice support meetings for all sites included in the model to provide feedback, access support, share lessons learned, and celebrate successes.
 - Include clinical operations staff and enabling departments

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 and 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.

Site Support Materials & Protocols

HMOC: Virtual MRP is designed to be implemented consistently at a provincial level while being tailored to the realities of each site and community.

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

- Orientation to HMOC: Virtual MRP and FAQ
- Patient pamphlet and poster
- Beginning and end of shift protocols
- Transfer protocols, pathways, and contact information
- Escalation pathways
- Emergency response procedures
- Consultation pathways for specialists and contact information
- Hours of operation/on-call back up of lab and diagnostic services
- Local pharmacy info for UPCCs.
- On-call MRP contact (as needed)



Checklist: HMOC: Virtual MRP Frontline Quick Start Checklist



Checklist: Troubleshooting & Reporting Checklist



Checklist: HMOC: Virtual MRP Beginning & End of Shift Checklist



Illustrative Case Example: Link-ED Site Support Resource Guide



Illustrative Case Example: Priority considerations for staff

Teams with experience implementing HMOC: Virtual MRP commonly highlight the following considerations:

- Role clarity early on: When it is unclear whether care is being delivered virtually or in-person, uncertainty can arise. Clear definitions, scripts, and written workflows help reinforce shared understanding.
- Change management effort: HMOC: Virtual MRP implementation often benefits from structured onboarding, local champions, ongoing coaching, and rapid iteration during early rollout.

- **Workload impacts:** Virtual care does not automatically reduce workload. Without intentional workflow design, documentation requirements, escalation pathways, nursing workflows, and communication tools can increase burden.
- **Staffing sustainability:** Models tend to be more sustainable when staffing expectations are realistic and consistently met. Feasible shift design supports engagement and reduces burnout risk.
- **Downtime reality:** Technology downtime is expected overtime. Confidence and safety are supported when downtime plans are clear, familiar, and practiced.

Patient Assignment for Virtual Care

Patient assignment within the Hybrid Model of Care must be intentional, team-based, and grounded in patient safety, clinical appropriateness, and local capacity. Patients should be assigned to virtual care only when their acuity and care needs can be safely managed through virtual assessment with appropriate onsite clinical support, technology, staffing, and escalation pathways in place.

Assignment decisions should consider patient stability, the need for hands-on assessment, nursing workload and onsite skill mix, availability of diagnostics and allied health supports, and the patient's ability and willingness to engage in virtual care, including language, accessibility, cultural, and individual preferences.

Suitability should be determined collaboratively by onsite staff and the virtual Most Responsible Provider (MRP) using structured communication (e.g., huddles, rounds, SBAR), with shared accountability and a low threshold to escalate or reassign care as conditions change. Standardized patient assignment tools support consistency but do not replace clinical judgment. All assignment decisions, patient consent, cultural considerations, and escalation triggers must be clearly documented to support continuity, transparency, and safe transitions of care.

Early implementation consideration: During initial phases, patient assignment may be more conservative and influenced by virtual provider experience and familiarity with onsite teams, with scope expanding over time as confidence and experience with hybrid workflows increase.



Checklist: Virtual Care Decision-Making Checklist for Triage Patients



Illustrative Case Example: Patient Assignment

A seasoned virtual care physician in BC reports that virtual MRP and onsite staff confidence play a large role in patient assignment to virtual care. “As an experienced virtual physician, I am confident to run a code from my remote location; however, it depends on the onsite team if they are comfortable as well. There are other virtual physicians who have only done a handful of shifts, they are getting used to providing care from a remote location, and don’t know the onsite staff very well yet; these folks would have a very different level of confidence when it comes to assigning patients to virtual care. Clinical support tools are helpful, but keep in mind that as you work more with or as a virtual MRP, your confidence will increase. If you really aren’t sure, calling the virtual MRP to decide if the patient is

suitable for virtual care, is a great option; they can help you decide and at the very least, get the patient started on their care journey.”



Illustrative Case Example: Examples of Patient Assignment Tools in Virtual Care

- Emergency Department Virtual Care Patient Assignment Tool
- Canadian Emergency Department Information System (CEDIS) Presenting Complaint List (V2.0)
- Inpatient Unit Patient Assignment Decision Support Tool
- Virtual Primary Care Patient Assignment Tool

Virtual Team Support Materials & Protocols

Situational Awareness (SA) for Virtual Providers & Virtual Support Staff

Safe HMOC: Virtual MRP depends on shared situational awareness between onsite teams and virtual MRPs, especially if supporting multiple sites or managing competing requests.

- Clinical Site Detail Page (site capabilities and capacity, staffing model, hours, escalation/transfer pathways, diagnostics and pharmacy access, EMR workflows & other documentation systems)
- Local referral pathways (e.g., Pathways/registry links or an equivalent local directory) and referral rules
- Community context snapshot (population characteristics and demographics, languages, Indigenous Nations/territories, rural/remote/away-from-home considerations)
- Cultural supports & access supports (Indigenous Patient Navigators, Elders/Knowledge Keepers where available, interpretation process, accessible communication options)
- “What’s different here” quick tips (site-specific constraints that affect care planning: transport limitations, weather impacts, service gaps, after-hours realities)
- Invitation to beginning and end of shift huddles
- A way for onsite staff to see virtual provider availability status (e.g., “in encounter,” “available,” “responding to escalation”).

Documentation Standards

Virtual MRP documentation must meet the same clinical and medico-legal standards as in-person documentation and must be accessible to the onsite team in real time or near-real time.

- Documentation into the same Electronic Health Record at site is recommended
- If this is not available, documentation into an independent EHR is required with transmission of information to/from site via secure mechanism

Consideration: Onboarding Considerations for Providers New to the Local System

Onboarding considerations for international (foreign) trained providers new to the local system centred on communication readiness. Approaches described included longer orientation to the community and local practice environment, and the use of buddy or paired shifts to build familiarity with local workflows prior to or during early virtual coverage. In this context, HMOC: Virtual MRP was described as adding an

additional layer of support through the availability of onsite teams and shared backup during care delivery.



Rural and Remote Spotlight: Resource realism for virtual providers

Rural/remote sites may have limited diagnostics, medication availability, and interventions. Virtual providers must understand local constraints and practice within what is realistically available.

Design implication: Include a local capability orientation for virtual providers (what tests, meds, imaging, transfer options exist) and embed this into decision-making workflows. Avoid recommendations that cannot be acted on locally.

Minimum safe standard: Virtual providers must know the local escalation/transport realities and adapt plans accordingly.

If/Then Adaptation: If a resource is not available locally, then the plan must specify an alternative pathway (clinical workaround, observation, transfer trigger) rather than simply noting what the site lacks.

Fostering Interprofessional Collaboration in a Hybrid Environment

Trust and rapport between MRPs, nursing, and the broader care team are foundational to quality care, efficiency, and patient experience. In hybrid models, trust may take longer to establish particularly for virtual MRPs requiring deliberate attention and structure.

Recommended activities to support interprofessional collaboration:

- 1. Clarify roles and responsibilities**
Clearly define team roles in the virtual care context, including accountability for clinical decisions, documentation, follow up, and technology.
- 2. Establish regular communication touchpoints**
Use scheduled team huddles, structured tools (e.g., SBAR), and secure, user-friendly platforms to support consistent information sharing.
- 3. Build team cohesion and trust**
Foster psychological safety through inclusive meetings, use of video where possible, and informal check-ins or meet and greets beyond clinical discussions.
- 4. Promote cultural safety and patient centred care**
Respect cultural differences, use interpreters and appropriate resources, and create a virtual environment that honours patient identity and preferences.
- 5. Address conflict proactively**
Establish clear protocols for decision making, conflict resolution, and escalation in virtual settings.
- 6. Prepare and engage patients and families**
Support patients with technology readiness, privacy considerations, and clear, jargon free communication; involve families when appropriate.
- 7. Use technology competently**
Ensure all team members are trained on virtual tools, identify a technology support lead, and have contingency plans for technical issues.

8. Commit to continuous learning and improvement

Collect feedback from patients and team members and regularly reflect on team processes to improve hybrid care delivery.



Template: HMOC: Virtual MRP Care Huddle Template



Template: HMOC: Virtual MRP SBAR Communication Template



Illustrative Case Example: LINK-ED Virtual Huddles

In the first month of LINK-ED implementation, teams across sites used structured virtual huddles as part of early operations to support coordination and familiarity.

“Great engagement with nursing on the virtual huddles, able to get team comfortable with each other and ensure they know they are supported”

This example demonstrates that structured huddles are not just a communications tactic - they are a trust-building practice and a place for active PDSA cycles. During early implementation and soft launch, consistent huddles support role clarity, psychological safety, and faster adoption across hybrid teams.

Patient & Family Support Materials & Protocols

This section outlines the minimum standards and practical protocols to ensure patients and families experience safe, accessible, culturally respectful, and understandable care within a Hybrid Model of Care (HMOC: Virtual MRP).

Patient Readiness, Education, and Orientation

Successful integration of virtual care depends on early and clear patient preparation.

Minimum expectations:

- Provide advance notice when virtual care will be used.
- Explain what to expect before, during, and after the encounter.
- Offer simple education materials to support understanding and comfort.

Core materials (adapt locally):

- Patient facing- brochure (what HMOC: Virtual MRP is, who is involved, what to expect).
- Patient facing- poster (visible reminder in care areas).
- Optional pre/post- visit- survey to assess understanding and experience.



Illustrative Case Example: Patient and Family Education Materials

- **Interior Health Virtual Care Brochure**
- **Interior Health Virtual Care Poster**

Accessibility and Accommodation

Patients may have multiple or intersecting accessibility needs (e.g., hearing loss and low vision, cognitive disability and language barriers, low digital literacy). Accessibility planning should consider the diverse needs and preferences of people with disabilities, including individuals who are Deaf, deafblind, hard of

hearing, have vision loss, cognitive disabilities, communication challenges, or other accessibility requirements. Organizations should establish processes to identify and arrange appropriate supports based on individual needs and preferences.

HMOC: Virtual MRP teams must:

- Assess accessibility needs early and throughout the care journey.
- Consider combined needs rather than single accommodations.
- Layer supports as required (e.g., interpreter + captioning + large -print materials).
- Adjust the modality of care (video, phone, in person) when virtual care cannot safely meet needs.

When barriers cannot be reasonably addressed, alternate care modalities must be offered. Accessibility supports should be incorporated into the care workflow and tested with the selected HMOC: Virtual MRP technology to ensure they can be effectively used during virtual encounters.

Language Access

Equitable access to HMOC: Virtual MRP requires proactive language planning.

Standard workflow:

- Identify preferred language and communication needs at intake or during care.
- Access professional interpretation or communication supports as needed.
- Confirm interpreter participation and technology setup prior to the visit.
- Document interpreter use, language, and any communication barriers.
- Provide follow up information in the patient's preferred language or accessible format where available.

Operational considerations:

- Provincial Language Services should be integrated into 24/7 workflows.
- Interpretation services must be tested with the selected HMOC: Virtual MRP technology.
- Train staff, patients, and families on accessing language services in virtual care.



Resource: Accessing Provincial Language Services

Digital Literacy and Technology Support

Patient digital readiness varies and must not limit quality of care.

HMOC: Virtual MRP teams should:

- Assess patient familiarity with technology.
- Offer education, practice sessions, and written or visual instructions.
- Provide advance reminders for virtual visits.
- Involve caregivers or support persons when appropriate.

Patients with low digital literacy must be informed of their right to receive the same standard of care as in person services. When digital barriers cannot be resolved, alternate modalities must be provided.

Family and Support Person Involvement

Family, caregivers, and support persons can play a critical role in HMOC: Virtual MRP .

Expectations:

- Explain the role of family/support persons and obtain patient consent for involvement.

- Document who is present during virtual encounters and their role.
- Respect patient preferences regarding family involvement and decision making.

Patient Rights and Responsibilities

Patients have the right to:

- Understand who is providing their care, including when the MRP is virtual.
- Receive information in a language and format they can understand.
- Ask questions, involve family/support persons (with consent), and participate in decisions.
- Receive culturally safe, respectful, and dignified care.
- Raise concerns or complaints without fear of negative impact on care.

Patients are encouraged to:

- Share relevant health information and concerns.
- Speak up if they do not understand, cannot hear/see, or need supports.
- Share preferences that support culturally safe care.



Illustrative Case Example: Tests and Imaging - Explanation and Access

During a virtual-supported visit, patients may seek to understand what tests or imaging showed, including requesting to view an image. Within the hybrid workflow, the care team can provide a clear, plain-language explanation of results and, where feasible using available local tools, support patient viewing of relevant images or findings during the interaction. When direct viewing is not available at the time of the encounter, patients can be given a brief explanation of how results are typically accessed locally through established site processes.

Consent and Privacy for Virtual Care

Patient Information and Consent

Patients must be informed about:

- The nature, purpose, and scope of virtual MRP involvement.
- The virtual modality being used (e.g., phone, video, secure messaging).
- Benefits and limitations of virtual care, including when in person escalation is required.
- Privacy and confidentiality considerations, including inherent electronic risks.
- What is required to participate (device, connectivity, private location).
- Available supports and what to expect during the process.
- The option to decline virtual care without compromising access to in person care, where feasible.
- Alternative care options when appropriate.
- Whether any part of the encounter will be recorded (explicit consent required).

Consent must be documented, including any accommodations used (e.g., interpreter, captioning, caregiver present).

Provider Responsibilities (Virtual MRPs)

Virtual MRPs must obtain and document informed consent in the legal record of care, including:

- Confirmation of patient identity.
- Modality used and patient location.
- Discussion of clinical limitations, privacy risks, and mitigation measures.

- Circumstances requiring in person escalation.
- Confirmation that the patient agreed to proceed and had an opportunity to ask questions.
- Consent for recording, if applicable.

Consent must be re-confirmed when:

- One year has passed since the last consent.
- There is reason to believe the patient does not fully understand risks.
- The virtual solution or modality changes.



Template: Consent Scripts

Inclusivity

HMOC: Virtual MRP workflows must support inclusion, belonging, and safety for all patients.

Key principles:

- Respect cultural identity, language, gender identity, family structures, and lived experience.
- Support preferred communication approaches and respectful introductions.
- Enable appropriate family involvement with consent.

Indigenous Specific Protocols

Indigenous Specific Anti-Racism (ISAR) in Action (minimum practices):

- Offer language services and clear introductions.
- Document family/kinship involvement and preferences.
- Provide technical coaching and camera off options.
- Ask about traditional medicines and coordinate with policy.
- Use plain language summaries and confirm understanding.
- Engage Indigenous Patient Navigators and document warm hand-offs.
- Log racism or safety concerns and follow established pathways

Feedback, Complaints, and Continuous Improvement

Patients, families, and staff must have clear and safe ways to provide feedback.

Minimum feedback channels:

- Realtime bedside check-ins after virtual encounters.
- Post visit surveys (QR, digital, or paper).
- Staff issue logs and debrief huddles during launch and ongoing operations.
- Community based feedback mechanisms where appropriate.

Standard response pathway:

- Acknowledge concerns promptly and ensure immediate safety.
- Escalate to Site Operational and Clinical Leads as required.
- Document concerns and actions taken.
- Follow up with the patient/family and provide next steps.
- Review themes in CQI and implement improvements (PDSA).

Cultural safety and ISAR related concerns:

- Offer culturally safe reporting options and supports.
- Involve Indigenous Health teams the same day where applicable.
- Prioritize respectful listening; do not require patients to prove harm.
- Close the loop with patients, families, and communities and monitor for recurrence.

Section 6: Pilot Conclusion and Sustainment

This section outlines how Hybrid Models of Care (HMOC) transition from a project supported pilot to business as usual operations, with clear accountability, stable supports, and ongoing quality improvement.

Pilot Conclusion

As a pilot reaches stability, teams should formally close the implementation phase while reinforcing learning and readiness for sustainment.

Key activities include:

- **Project debrief & evaluation:** Conduct a structured debrief with the project team to document lessons learned, risks, and recommended improvements. Evaluate project and implementation processes.
- **Ongoing staff feedback:** Continue regular staff debriefs as part of continuous improvement to reinforce change and surface emerging issues.
- **Partner experience assessment:** Assess clinician and patient experience and readiness to continue, using surveys, interviews, and/or focus groups.
- **Transition to operations:** Once HMOC: Virtual MRP is deemed ready for sustainment, transfer ownership to operations through a defined series of meetings and written handover materials.

During this period, the **project team role narrows** to change management support, quality improvement, and evaluation, while operational teams prepare to assume day to day accountability.

Transition to Operations

Phased Transition Approach

Teams may describe the move from pilot to sustainment as a phased progression:

Phase 1 – Project-Led Stabilization: Project support remains active while workflows, staffing, and technology stabilize.

Phase 2 – Shared Ownership: Responsibilities are gradually transferred to operations, with project support shifting to an advisory role.

Phase 3 – Operations-Led Delivery: Operations lead day-to-day service delivery with minimal project oversight.

Phase 4 – Project Closure: Project structures are formally stood down and HMOC: Virtual MRP operates fully under operational governance.

****Readiness triggers** (e.g., stable workflows, consistent safety indicators, validated SOPs) should guide transition timing rather than fixed dates.

Governance and Accountability in Sustainment

In steady state operations, teams should document:

- **Operational ownership:** Named operational and clinical leads with authority to adjust workflows and pause HMOC: Virtual MRP activity if safety concerns arise.
- **Decision making authority:** Clarity on who can approve scheduling changes, clinical model adjustments, and expansions or contractions of virtual coverage.
- **Governance cadence:** Defined forums (e.g., quarterly reviews) for oversight, escalation, and continuous improvement.

Minimum Sustainment Components

Sustainment planning should confirm, at minimum:

- **Standard operating procedures:** Current SOPs for huddles, patient assignment, escalation, downtime, documentation, and follow up.
- **Support model:** Defined technology support and clinical escalation pathways, with stabilization calls that taper as maturity increases.
- **Training sustainment:** Onboarding packages for new staff and virtual MRPs, with planned refresher training.
- **Performance monitoring:** Agreed KPIs and dashboard cadence, with regular review of trends and issues.
- **Equity and cultural safety:** Ongoing access to interpretation services, Indigenous navigation pathways, and culturally safe feedback mechanisms.

Capability Transfer and Project Closure

Capability Transfer Package

As ownership shifts, teams may develop a concise package outlining:

- Scheduling processes and operational points of contact
- Clinical and technology escalation pathways
- Transfer of routine meeting leadership to operations
- Project role transitioning to time limited advisory support

Project Close Criteria

Projects may close when:

- Core processes are owned and operated by operations
- Evaluation and reporting are embedded in routine practice
- Governance structures are confirmed
- Key risks are mitigated or formally accepted

Post-closure, quarterly operational reviews, community-of-practice touchpoints, and a clear escalation pathway for emerging issues is recommended



Illustrative Case Example: LINK-ED Sustainability & Transition Plan

Continuous Quality Improvement (CQI)

CQI continues beyond the pilot, shifting from rapid PDSA cycles to a stable cadence:

- **Monthly:** Review KPIs, incidents and near misses, escalation events, technology issues, workload signals, and patient feedback.

- **Quarterly:** Deeper mixed methods review, workflow refresh, training updates, and sharing of learnings at regional and provincial tables.
- **Ongoing:** Maintain an issue log with named owners and target close-out dates, and share “you said / we did” summaries with staff.

Workforce and Resource Sustainment

Virtual MRP Pool Maintenance

Sustainment may include:

- Maintaining current rosters of privileged providers by site and scope
- Standardized orientation to local context
- Monitoring coverage reliability, sick calls, and surge capacity
- Peer support and clinical coaching for virtual providers
- Routine audits of handover quality with targeted refreshers

Financial and Resource Sustainability

Teams may plan for:

- Ongoing funding for virtual shifts, operational supports, Digital Health, and CQI
- Monitoring unintended impacts on in person services
- Anticipating technology replacement cycles and licensing renewals
- Documenting resourcing assumptions and interim coverage strategies during transition

Performance Monitoring and Benchmarks

A minimum KPI set should align with provincial evaluation intent (access, safety, experience, equity, workforce), with automated capture where feasible.

Example benchmarks (after stabilization):

- Primary care: ~3 patients/hour
- ED: ~2 patients/hour
- Inpatient: 10–12 patient roster per 12-hour shift

If targets are not met, teams may assess technology usability, nursing and virtual physician competency, interprofessional trust, chart completeness, referral patterns, and patient accessibility supports.

*** note: these benchmarks are examples from pilots of virtual MRP services across Canada*

Scalability and Expansion

Scalability requires balancing standardization with local adaptation.

Key considerations include:

- Leadership approval and strategic alignment
- Standardized core components (roles, escalation, training)
- Interoperable systems and shared governance
- Ability to replicate successful models and share lessons learned
- Monitoring unintended consequences as services expand

Approaches may differ when:

- Expanding to additional sites using the same HMOC: Virtual MRP model
- Introducing a new HMOC: Virtual MRP model within an existing health authority

Resource Prioritization

BC is faced with limited resources – funding and MRPs, 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 and Access:** Ensure equitable access to care across all regions.
4. **Implementation Feasibility:** Overall site readiness, infrastructure availability, clinical support champions.



Illustrative Case Example: HMOC: Virtual MRP Resource Prioritization Rubric

Section 7: Recommendations for National Applications

This National Adaptation Guide supports jurisdictions across Canada in adopting and adapting the Hybrid Model of Care framework. It identifies which components of the model are universal and can be scaled nationally, and which components require local or jurisdiction specific customization related to legislation, workforce, digital infrastructure, Indigenous governance, and clinical practice context.

Universal Components (Adopt as Is)	Jurisdiction Specific Components (Customize for Local Context)
These elements of HMOC: Virtual MRP are stable across all Canadian care environments and can be directly scaled nationally.	These areas vary significantly across Canada and must be adapted to local structures, policies, and infrastructure.
Service Model Definitions - Hybrid Onsite - Hybrid On Call - Fully Virtual	Licensing, Credentialling & Liability - Regulatory college requirements (e.g., CPSO, CPSBC, CPNS) - Cross provincial licensure rules - Privileging processes - Medical legal liability frameworks
Readiness Assessment Structure - Governance & leadership - Staffing & workload - Indigenous partnership (distinctions based) - Technology readiness - Clinical workflows - Change management & engagement - Risk mitigation	Physician Compensation & Funding Models - Virtual care fee codes vary by province - Alternative payment plans (APPs) and regional incentives differ - Union, collective, and contractual agreements - Budget models for sustainability versus pilot phase funding
Virtual–Onsite Collaboration Principles Clear MRP accountability	Digital Health Infrastructure

- Standardized handover practices - Escalation pathways - Documentation expectations - Use of structured communication tools (e.g., SBAR)	- Shared EMR availability (CST/Cerner, Meditech, Epic, paper based, hybrid) - Differences in bandwidth and connectivity - Access to province wide systems (ex. provincial e-prescribing etc.) - Access to diagnostic systems (e.g., PACS, DI portals) - Province specific privacy legislation - Integration with local virtual care platforms - Local requirements for remote order entry and documentation
Virtual–Onsite Collaboration Principles - Clear MRP accountability - Standardized handover practices - Escalation pathways - Documentation expectations - Use of structured communication tools (e.g., SBAR)	Indigenous Governance & Protocols - OCAP® requirements - Treaty obligations & self government agreements - Nation specific cultural protocols and expectations - Local Indigenous governance structures (e.g., FNHA, FNIHB regions, Métis Nation structures) - Requirements for ceremony, community approvals, and oversight
Evaluation & Quality Framework - Alignment to the Quintuple Aim - Patient experience - Provider experience - Equity & cultural safety - Access & timeliness - Clinical safety indicators - Data for continuous improvement	Local Clinical Context - Availability of on-site physicians, nurses, and allied health - Variability in nurse scope of practice - Diagnostic imaging and lab availability (e.g., hours, modalities) - Local transport, emergency response, and retrieval capabilities - Referral pathways to specialty services - On-call structures and after-hours staffing realities
Cultural Safety & Accessibility Principles - Distinctions based Indigenous engagement (First Nations, Métis, Inuit) - Trauma informed and antiracist practice - Language access supports - Accessibility for people with disabilities - Recognition that cultural identity is protective in health care	Local Operational Capacity - Existence and size of Virtual Operations Teams - Capacity to support onboarding, training, and quality monitoring - Availability of project management and clinical informatics resources - Local change management support

Core Clinical & Operational Tools • Patient assignment decision factors • Workflow mapping templates • Change management templates • Project governance and roles & responsibilities structure • Communication and stakeholder engagement planning	Community Context & Population Needs • Rurality classification differs across provinces • Unique linguistic, cultural, and demographic needs • Access to primary care and continuity providers • Presence of unattached patients • Social determinants and local resource availability

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: Virtual MRP	Hybrid Model of Care
PIA	Privacy Impact Assessment
STRA	Security Threat and Risk Assessment
MOH	Ministry of Health
MRP	Most Responsible Provider
ED	Emergency Department
ECBC	Emergency Care BC
FNHA	First Nations Health Authority
Virtual Care	- Any interaction between patients and/or members of their circle of care, occurring remotely, with the aim of facilitating patient care (<i>Canada Institute for Health Information, 2024</i>) - The use of virtual technologies for remotely <i>interacting</i> with patients and other staff members in real-time: this includes for interpersonal communication, i.e., videoconferencing or instant messaging, as well as transmission of video and audio input such as physical assessment findings.
Hybrid Care	- A care model that includes virtual MRPMRPs directing the care for patients in hospitals alongside on-site staff including nursing. Staff may also include other on-site MRPMRPs or on-call MRPMRPs, depending on an organization's staffing capacity. - The goal of a hybrid care model is to augment in person care with virtual support NOT to replace it. - Prioritize in-person MRPMRP coverage whenever possible; virtual MRPMRPs are leveraged to support the capacity of on-site teams and prevent diversions/closures if an in-person MRPMRP is not available.
HSO	Health Standards Organization
UBC	University of British Columbia
IH	Interior Health
ISAR	Indigenous-Specific Anti-Racism
SBAR	Situation, Background, Assessment, Recommendation
EMR	Electronic Medical Record

Acronym/Term	Definition
IMIT	Information Management & Information Technology
LPN	Licensed Practical Nurse
ADKAR	Awareness, Desire, Knowledge, Ability, Reinforcement
PDSA	Plan-Do-Study-Act
Q&A	Questions & Answers
BCPSQC	BC Patient Safety & Quality Council

References Consulted/Related Materials

1. BC Centre for Disease Control (BCCDC). (n.d.). Culturally Safe Care. <http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/education-and-training/culturally-safe-care#:~:text=What%20is%20culturally%20safe%20care,discrimination%2C%20where%20people%20feel%20safe.>
2. BC Patient Safety & Quality Council (BCPSQC). (2025). British Columbia health quality matrix. [BC Health Quality Matrix - Health Quality BC. BC Health Quality Matrix - Health Quality BC](#)
3. Canadian Association of Emergency Physicians (CAEP). (2025). Optimizing the role of virtual care in emergency medicine: A CAEP position statement – Full manuscript DRAFT. Canadian Association of Emergency Physicians. [Optimizing the role of virtual care in emergency medicine | CAEP](#)
4. Canada Health Infoway. (2022). Clinician Change Virtual Care Toolkit. <https://www.infoway-inforoute.ca/en/component/edocman/resources/clinician-change-management/6378-clinician-change-virtual-care-toolkit>
5. Canadian Institute for Health Information. (n.d.). Virtual care in Canada. <https://www.cihi.ca/en/virtual-care-in-canada>
5. Canadian Medical Association. (2022). Virtual care in Canada: Progress and potential. <https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf>
6. Clinician Change Virtual Care Toolkit. (2022, February 15). Providing safe and high-quality virtual care: A guide for new and experienced users. Canada Health Infoway. <https://www.infoway-inforoute.ca/en/component/edocman/6378-clinician-change-virtual-care-toolkit/view-document?Itemid=103>
7. College of Physicians and Surgeons of British Columbia. (2022). Practice standard: Virtual care. [CPSBC-PS-Virtual-Care.pdf](#)

8. *Developing a Rural and Remote Health Strategy: Working together to improve healthcare equity and access for people in our most rural and remote communities.* Presentation to BC Ministry of Health, November 14, 2024.
8. Emergency Care BC. (n.d.). ED triage tool for virtual care.
9. Interior Health (2024). *Virtual Primary Care Guideline.*
10. Interior Health (2025). *Patient Assignment Tool: Inpatient Care.*
11. Joint Collaborative Committees. (2021). *Appropriate use of virtual care Statements.* [JCC-Appropriate-Use-of-Virtual-Care-Statements-2021-ID-458860.pdf](https://www.jcc-vc.ca/sites/default/files/2021-12/2021-12-14-Appropriate-Use-of-Virtual-Care-Statements-2021-ID-458860.pdf)
12. Karczewski, T., Stephens, J. M. L., Karczewski, D., Feizizadeh, S., Patel, A. K., Pinero, M. M. A., Olsen, M., & Thompson, M. L. (2026). *Virtual Care and Telehealth for Improving Healthcare Access in Rural Western Canada and the Western United States: A Scoping Review and Narrative Synthesis.* *Journal of Clinical Medicine*, 15(12), 4749. <https://doi.org/10.3390/jcm15124749>
11. Nott, S., Wingfield, G., Haigh, A., Luscombe, G. M., Thompson, A. E., Saurman, E., Shaw, T., Von Huben, A., Howard, K., & Wilson, A. (2024). *The virtual rural generalist service: A hybrid virtual model of care designed to improve health access and outcomes in rural and remote communities.* *Medical Journal of Australia*, 221(S11). <https://doi.org/10.5694/mja2.52529>
12. Provincial Health Services Authority. (n.d.). *Our Commitment to Truth & Reconciliation.* Retrieved on Oct 10, 2024 from <http://www.phsa.ca/about/who-we-are/eradicating-indigenous-specific-racism/our-commitment>
13. The Prosci ADKAR® Model | Prosci, <https://www.prosci.com/methodology/adkar>, accessed on January 22, 2026.
12. Thompson, A. E., Shaw, T., Nott, S., Wilson, A., & Saurman, E. (2024). *Patient and carer experiences of hospital-based Hybrid Virtual Medical Care: A qualitative study.* *Medical Journal of Australia*, 221(S11). <https://doi.org/10.5694/mja2.52520>
13. Truth and Reconciliation Commission of Canada. (2012). *“Truth and Reconciliation Commission of Canada: Calls to Action,” Exhibits*, accessed October 28, 2024, <https://exhibits.library.utoronto.ca/items/show/2420>.
14. Turpel-Lafond, M.E. (November, 2020). *Addressing Racism Review Summary Report* accessed on Oct 10, 2024, <https://enqage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>
13. Virtual Care Clinical Reference Group (VCCRG) (2023). *Real-Time Virtual Support improving health equity and access in British Columbia.* [Real-Time Virtual Support improving health equity and access in British Columbia - RCCbc](https://www.vccrg.ca/real-time-virtual-support-improving-health-equity-and-access-in-british-columbia)